

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04296
245

4305

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville		c. LENGTH OF STAY IN 1b 1 yr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5800--39th Avenue				d. STREET ADDRESS 5800--39th Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last STEPHEN (NMN) AICH				4. DATE OF DEATH Month Day Year April 25th, 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 10th, 1864	9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, (are included)) Locomotive Engineer		10b. KIND OF BUSINESS OR INDUSTRY Union Pacific RR		11. BIRTHPLACE (State or foreign country) Madison, Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Raron			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Helen Danielson, 5800--39th Ave., West Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 25th, 1956			
EXAMINER'S NAME (Type) John T. Maloney		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/25/1956	22c. NAME OF CEMETERY OR CREMATORY Highland Cemetery	22d. LOCATION (City, town, or county)	(State) Salina, Kansas			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., Riverdale, Md.			24a. REC'D BY REGISTRAR DATE April 26, 1956	24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe Deputy			

1
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1805

NAME OF DECEASED: [illegible]
 SEX: [illegible] AGE: [illegible]
 DATE OF DEATH: [illegible]
 PLACE OF DEATH: [illegible]
 OCCUPATION: [illegible]
 CAUSE OF DEATH: [illegible]
 MANNER OF DEATH: [illegible]
 SIGNATURE OF EXAMINER: [illegible]
 DATE: [illegible]

RECEIVED
 APR 27 1956
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Prior to this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4315

CERTIFICATE OF DEATH

04297

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3rd Cherry Md.</u>				c. LENGTH OF STAY IN 1b <u>5 MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>77 Prince George's Gen. Hosp.</u>				d. STREET ADDRESS <u>7120 Trebleton St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Cooper Armstrong</u>				4. DATE OF DEATH Month Day Year <u>April 11 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 25, 1890</u>		9. AGE (In years last birthday) <u>65</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BRICKLAYER (ANALYST)- BUILDING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TEXAS, MD.</u>		11. BIRTHPLACE (State or foreign country) <u>TEXAS, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN M. ARMSTRONG</u>				14. MOTHER'S MAIDEN NAME <u>LILLIAN SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		17. INFORMANT Address <u>HELEN A. KREIS - 4131 NORFOLK AVE. BALTIMORE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Haem. a</u> DUE TO (c) <u>Carcinoma of Urinary Bladder</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>1 WEEK</u> <u>6 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 28, 1955</u> to <u>April 11, 1956</u> , that I last saw the deceased alive on <u>April 10, 1956</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm. A. Halbrook</u> M.D.				ADDRESS (Street, city or town, state) <u>4550 Prince George's Gen. Hosp. Church, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Wm. A. Halbrook</u>				DATE SIGNED <u>4/11/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/14/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>COLMAR MANOR R 600 Co, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co, Riverdale, MD</u>				24a. REC'D BY REGISTRAR DATE <u>4/12/56</u>		24b. REGISTRAR'S SIGNATURE <u>Amanda Downey</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>APR 15 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>HOME</i>	
7. CAUSE OF DEATH <i>HEART DISEASE</i>		8. MANNER OF DEATH <i>NATURAL</i>		9. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
10. SIGNATURE OF REGISTRAR <i>[Signature]</i>		11. SIGNATURE OF WITNESS <i>[Signature]</i>		12. SIGNATURE OF DECEASED <i>[Signature]</i>	
13. SIGNATURE OF DECEASED <i>[Signature]</i>		14. SIGNATURE OF DECEASED <i>[Signature]</i>		15. SIGNATURE OF DECEASED <i>[Signature]</i>	
16. SIGNATURE OF DECEASED <i>[Signature]</i>		17. SIGNATURE OF DECEASED <i>[Signature]</i>		18. SIGNATURE OF DECEASED <i>[Signature]</i>	
19. SIGNATURE OF DECEASED <i>[Signature]</i>		20. SIGNATURE OF DECEASED <i>[Signature]</i>		21. SIGNATURE OF DECEASED <i>[Signature]</i>	
22. SIGNATURE OF DECEASED <i>[Signature]</i>		23. SIGNATURE OF DECEASED <i>[Signature]</i>		24. SIGNATURE OF DECEASED <i>[Signature]</i>	
25. SIGNATURE OF DECEASED <i>[Signature]</i>		26. SIGNATURE OF DECEASED <i>[Signature]</i>		27. SIGNATURE OF DECEASED <i>[Signature]</i>	
28. SIGNATURE OF DECEASED <i>[Signature]</i>		29. SIGNATURE OF DECEASED <i>[Signature]</i>		30. SIGNATURE OF DECEASED <i>[Signature]</i>	
31. SIGNATURE OF DECEASED <i>[Signature]</i>		32. SIGNATURE OF DECEASED <i>[Signature]</i>		33. SIGNATURE OF DECEASED <i>[Signature]</i>	
34. SIGNATURE OF DECEASED <i>[Signature]</i>		35. SIGNATURE OF DECEASED <i>[Signature]</i>		36. SIGNATURE OF DECEASED <i>[Signature]</i>	
37. SIGNATURE OF DECEASED <i>[Signature]</i>		38. SIGNATURE OF DECEASED <i>[Signature]</i>		39. SIGNATURE OF DECEASED <i>[Signature]</i>	
40. SIGNATURE OF DECEASED <i>[Signature]</i>		41. SIGNATURE OF DECEASED <i>[Signature]</i>		42. SIGNATURE OF DECEASED <i>[Signature]</i>	
43. SIGNATURE OF DECEASED <i>[Signature]</i>		44. SIGNATURE OF DECEASED <i>[Signature]</i>		45. SIGNATURE OF DECEASED <i>[Signature]</i>	
46. SIGNATURE OF DECEASED <i>[Signature]</i>		47. SIGNATURE OF DECEASED <i>[Signature]</i>		48. SIGNATURE OF DECEASED <i>[Signature]</i>	
49. SIGNATURE OF DECEASED <i>[Signature]</i>		50. SIGNATURE OF DECEASED <i>[Signature]</i>		51. SIGNATURE OF DECEASED <i>[Signature]</i>	
52. SIGNATURE OF DECEASED <i>[Signature]</i>		53. SIGNATURE OF DECEASED <i>[Signature]</i>		54. SIGNATURE OF DECEASED <i>[Signature]</i>	
55. SIGNATURE OF DECEASED <i>[Signature]</i>		56. SIGNATURE OF DECEASED <i>[Signature]</i>		57. SIGNATURE OF DECEASED <i>[Signature]</i>	
58. SIGNATURE OF DECEASED <i>[Signature]</i>		59. SIGNATURE OF DECEASED <i>[Signature]</i>		60. SIGNATURE OF DECEASED <i>[Signature]</i>	
61. SIGNATURE OF DECEASED <i>[Signature]</i>		62. SIGNATURE OF DECEASED <i>[Signature]</i>		63. SIGNATURE OF DECEASED <i>[Signature]</i>	
64. SIGNATURE OF DECEASED <i>[Signature]</i>		65. SIGNATURE OF DECEASED <i>[Signature]</i>		66. SIGNATURE OF DECEASED <i>[Signature]</i>	
67. SIGNATURE OF DECEASED <i>[Signature]</i>		68. SIGNATURE OF DECEASED <i>[Signature]</i>		69. SIGNATURE OF DECEASED <i>[Signature]</i>	
70. SIGNATURE OF DECEASED <i>[Signature]</i>		71. SIGNATURE OF DECEASED <i>[Signature]</i>		72. SIGNATURE OF DECEASED <i>[Signature]</i>	
73. SIGNATURE OF DECEASED <i>[Signature]</i>		74. SIGNATURE OF DECEASED <i>[Signature]</i>		75. SIGNATURE OF DECEASED <i>[Signature]</i>	
76. SIGNATURE OF DECEASED <i>[Signature]</i>		77. SIGNATURE OF DECEASED <i>[Signature]</i>		78. SIGNATURE OF DECEASED <i>[Signature]</i>	
79. SIGNATURE OF DECEASED <i>[Signature]</i>		80. SIGNATURE OF DECEASED <i>[Signature]</i>		81. SIGNATURE OF DECEASED <i>[Signature]</i>	
82. SIGNATURE OF DECEASED <i>[Signature]</i>		83. SIGNATURE OF DECEASED <i>[Signature]</i>		84. SIGNATURE OF DECEASED <i>[Signature]</i>	
85. SIGNATURE OF DECEASED <i>[Signature]</i>		86. SIGNATURE OF DECEASED <i>[Signature]</i>		87. SIGNATURE OF DECEASED <i>[Signature]</i>	
88. SIGNATURE OF DECEASED <i>[Signature]</i>		89. SIGNATURE OF DECEASED <i>[Signature]</i>		90. SIGNATURE OF DECEASED <i>[Signature]</i>	
91. SIGNATURE OF DECEASED <i>[Signature]</i>		92. SIGNATURE OF DECEASED <i>[Signature]</i>		93. SIGNATURE OF DECEASED <i>[Signature]</i>	
94. SIGNATURE OF DECEASED <i>[Signature]</i>		95. SIGNATURE OF DECEASED <i>[Signature]</i>		96. SIGNATURE OF DECEASED <i>[Signature]</i>	
97. SIGNATURE OF DECEASED <i>[Signature]</i>		98. SIGNATURE OF DECEASED <i>[Signature]</i>		99. SIGNATURE OF DECEASED <i>[Signature]</i>	
100. SIGNATURE OF DECEASED <i>[Signature]</i>		101. SIGNATURE OF DECEASED <i>[Signature]</i>		102. SIGNATURE OF DECEASED <i>[Signature]</i>	

BUREAU V. S.

APR 16 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04298

4363 CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Prince Georges</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince Georges</u>	
CITY OR TOWN <u>Camp Springs</u>		LENGTH OF STAY (in this place) <u>12 yrs</u>		CITY OR TOWN <u>Camp Springs (Washington)</u>		(If rural give location) <u>22 D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS <u>5360 Edgewood Drive</u>			
3. NAME OF DECEASED (Type or Print) <u>George Haddaway BARTON</u>				4. DATE OF DEATH (Month) <u>April</u> (Day) <u>20</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>November 7, 1896</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food</u>		11. BIRTHPLACE (State or foreign country) <u>Kent Island, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. of A.</u>	
13. FATHER'S NAME <u>Edward Barton</u>				14. MOTHER'S MAIDEN NAME <u>Mary Katherine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>World War I</u>		16. SOCIAL SECURITY NO. <u>217-32-2600</u>		17. INFORMANT & ADDRESS <u>Mrs. Mary Barton 5360 Edgewood Dr. Washington 22, D.C.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) <u>Coronary Occlusion, Acute</u>						<u>15 min.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>						<u>Unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis Generalized</u>						<u>Unknown</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cirrhosis of Liver</u>						<u>10 years</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 11, 1956</u> , to <u>April 20, 1956</u> , that I last saw the deceased alive on <u>April 11, 1956</u> , and that death occurred at <u>9:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward H. Gibson</u>				DATE SIGNED <u>April 20, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>April 24-56</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Natl.</u>	
24. REC'D BY REGISTRAR <u>Edward F. Simmons</u>				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>1661-9th Hape Rd 2 E</u>	
DATE <u>April 21-56</u>				ADDRESS <u>2412 Minnesota Ave. S.E.</u>			

CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased (Print or write full name)

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Usual residence

7. Date of death

8. Time of death

9. Cause of death

10. Place of death

11. Signature of attending physician

12. Signature of registrar

13. Signature of informant

14. Signature of witness

15. Signature of funeral director

16. Signature of undertaker

17. Signature of cemetery

18. Signature of burial place

19. Signature of interment

20. Signature of record

21. Signature of office

22. Signature of department

23. Signature of state

24. Signature of union

25. Signature of country

26. Signature of world

27. Signature of universe

28. Signature of everything

29. Signature of nothing

30. Signature of somebody

31. Signature of nobody

32. Signature of anybody

33. Signature of everybody

34. Signature of no body

35. Signature of any body

36. Signature of every body

37. Signature of nobody's

38. Signature of anybody's

39. Signature of everybody's

40. Signature of no body's

41. Signature of any body's

42. Signature of every body's

43. Signature of nobody's

44. Signature of anybody's

45. Signature of everybody's

46. Signature of no body's

47. Signature of any body's

48. Signature of every body's

49. Signature of nobody's

50. Signature of anybody's

BUREAU V. S.

APR 30 1956

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4364 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04299

Reg. Dist. No. 243

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u> c. LENGTH OF STAY IN 1b <u>Transit</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bowie Race Track Grounds</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Georgia</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Atlanta</u> d. STREET ADDRESS <u>346 Wellington Street, S.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>William</u> Last <u>Boling</u>		4. DATE OF DEATH Month <u>April</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17, 1894</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi cab driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Boling</u>		14. MOTHER'S MAIDEN NAME <u>Prudy Reen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>259-05-387</u>	
17. INFORMANT Address _____ <u>Mrs Fred S. Norris, Same address.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year _____ Hour _____ a. m. _____ p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John J. Maloney</u> M.D. EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 2, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/5/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West View Cemetery</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Alanta Georgia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Maryland.</u>		24a. REC'D BY REGISTRAR <u>APR 5 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Mrs. J. Grigling</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4326 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

04300

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1410 Merrimack Drive				d. STREET ADDRESS 1410 Merrimack Drive			
3. NAME OF DECEASED (Type or print) First Eliza Middle Belle Last Bowen				4. DATE OF DEATH Month April Day 14 Year 1956			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 17, 1866	
9. AGE (In years last birthday) 89		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin L. Lanham				14. MOTHER'S MAIDEN NAME Ann (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 		17. INFORMANT Nellie Redmond, Same address.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c), stating the underlying cause lost. DUE TO Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 14, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/17/1956		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Prince Georges County, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.				ADDRESS 2901 14th St., N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR April 16 1956	
				24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

BUREAU V. 3

APR 18 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G-197 5-18-56 et

CERTIFICATE OF DEATH

Reg. Dist. No.

04301
231

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>38 Chester</i>		c. LENGTH OF STAY IN TB <i>16 days.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>77 Prince Georges General Hospital</i>		d. STREET ADDRESS <i>480 3 Central Avenue</i>	
3. NAME OF DECEASED (Type or print) First <i>Jacob</i> Middle <i>Boyer</i> Last		4. DATE OF DEATH Month <i>4</i> - Day <i>30</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-7-1885</i>
9. AGE (In years lost birthday) <i>70</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Washington, D.C.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Harry Boyer</i>		14. MOTHER'S MAIDEN NAME <i>Selinda Bright</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>Sp. American</i>	
17. INFORMANT <i>Statistic Card</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>177X Carcinoma of Prostate</i> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. f. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 12, 1956</i> to <i>April 29, 1956</i> , that I last saw the deceased alive on <i>April 29, 1956</i> , and that death occurred at <i>4:25 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Donald W. Mitchell</i>		ADDRESS (Street, city or town, state) <i>1756 45th NW Wash DC</i>	
DATE SIGNED <i>5/1/56</i>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>DONALD W. MITCHELL</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/2/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Washington Nat</i>		22d. LOCATION (City, town, or county) (State) <i>Wash. DC</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. W. Lee Sons Co.</i>		ADDRESS <i>Wash. D.C.</i>	
24a. REC'D BY REGISTRAR <i>5/1/56</i>		24b. REGISTRAR'S SIGNATURE <i>Amanda Dancy</i>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>May 2, 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. PRESENT ILLNESS <i>None</i>		15. SIGNATURE OF DECEASED <i>John A. Smith</i>	
16. SIGNATURE OF WITNESS <i>John A. Smith</i>		17. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>		18. SIGNATURE OF CLERK <i>John A. Smith</i>	
19. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		20. SIGNATURE OF DECEASED <i>John A. Smith</i>		21. SIGNATURE OF WITNESS <i>John A. Smith</i>	
22. SIGNATURE OF PHYSICIAN <i>John A. Smith</i>		23. SIGNATURE OF CLERK <i>John A. Smith</i>		24. SIGNATURE OF REGISTRAR <i>John A. Smith</i>	

BUREAU V. 2

MAY 3 1956

RECEIVED

TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, MAY 3, 1956.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04302

4365

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PR. GEO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>DORSEY RD.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BAUGHERTY C. BROOKS</u>		4. DATE OF DEATH Month Day Year <u>APR. 27 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-4-1912</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>A.H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>WASH., D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>ROLAND JACKSON</u>		14. MOTHER'S MAIDEN NAME <u>EMILY TAYLOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>WILLIAM BROOKS-</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Decompensation</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Renal Disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>natural cause</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 18</u> , 19 <u>45</u> , to <u>Apr 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Apr 25</u> , 19 <u>56</u> , and that death occurred at <u>6:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Evan Watts</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Washington 28 DC Apr 27 1956</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Removal</u>	<u>4-27-56</u>	<u>Stewart Funeral Home</u>	<u>30-A St. NE DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Stewart</u>		24a. REC'D BY REGISTRAR <u>4-28-56</u>	24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>

CERTIFICATE OF DEATH

PRINCE GEORGE
TOWNSHIP
DOESBY

BRAUNHARTY C. DOCKERY
FARMER CO. and 11-4-1912
WASH, D.C.
EMILY THAYER
WILLIAM DOCKERY

DEATH OF EMILY THAYER DOCKERY
WIFE OF WILLIAM DOCKERY
FARMER CO. and 11-4-1912
WASH, D.C.
EMILY THAYER
WILLIAM DOCKERY

BUREAU V. 2

MAY 1 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

04303

4317

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Prince Georges	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cheverly		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Mt. Rainier	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Prince Georges General Hospital		STREET ADDRESS (If rural give location) 3815 - 33rd street	
3. NAME OF DECEASED (Type or Print)	(First) Victor	(Middle) T.	(Last) Brooks
4. DATE OF DEATH	(Month) April	(Day) 13	(Year) 1956
5. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar. 6, 1876
9. AGE last birthday 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer U.S. Government	
11. BIRTHPLACE (State or foreign country) Van Wert, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore Brooks		14. MOTHER'S MAIDEN NAME Angeline Barton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. 214-34-6592	
17. INFORMANT Mrs. Helen Whitteather, Daughter			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

446X Immediate cause (a) Uremia	INTERVAL BETWEEN ONSET AND DEATH (week)
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Glomerular Nephritis	6 months
(c) Generalized Arteriosclerosis	2 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January 1, 1952, to April 13, 1956, that I last saw the deceased alive on April 13, 1956, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	4-16-56	Fort Lincoln Cemetery	Calmar Manor, Md.	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
April 15, 1956	Mrs. Jas. Devere	Mallett's Funeral Home, Inc.	3200 - R.I. Ave Mt. Rainier, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

APR 18 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film 67 5-18-56 et

4318

CERTIFICATE OF DEATH

04304

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. LENGTH OF STAY IN 1b <u>39 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				15			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>4205 Hamilton Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Burke</u> Last <u>Burke</u>				4. DATE OF DEATH Month <u>4</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-11-1884</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Months <u>7</u> Days <u>1</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edward Burke</u>				14. MOTHER'S MAIDEN NAME <u>Agnes (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>153X</u>			
17. INFORMANT <u>George H. McLain</u>				Address <u>1746 K. St. NW Wash. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adhesions following surgery</u> DUE TO (c) <u>Prosection of sigmoid for carcinoma</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks?</u> <u>1 month</u> <u>6 weeks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>7-29</u> p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3-21</u> , 19 <u>56</u> , to <u>4-20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-29</u> , 19 <u>56</u> , and that death occurred at <u>5:00</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5-1-56</u> DATE SIGNED <u>George H. McLain</u>							
ACTUAL SIGNATURE <u>George H. McLain</u> M.D.				ADDRESS <u>1746 K. St. NW Wash. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>George H. McLain, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-4-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harmony Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. McGuire</u>				ADDRESS <u>1820-9th St. NW</u>			
24a. REC'D BY REGISTRAR <u>5/2/56</u>				24b. REGISTRAR'S SIGNATURE <u>Umanda Dourney</u>			

(Emb. #5936) (D. #3285)

BUREAU V. 3

1956

2. 11. 1951

RECEIVED

4366

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Farmmount Heights</i>		c. LENGTH OF STAY IN 1b <i>4 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>708-58" Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Janie Elizabeth Butler</i>		4. DATE OF DEATH <i>April 4 1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-26-186</i>
9. AGE (In years last birthday) <i>69 yrs.</i>		10. IF UNDER 14 EAR <i>4</i> IF UNDER 24 HRS. <i>4</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Michael Butler</i>		14. MOTHER'S MAIDEN NAME <i>Georgiana Butler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Edith Butler</i>		Address <i>708-58" Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO (b) <i>Hypertension</i> DUE TO (c) <i>Diabetes mellitus</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility</i>		INTERVAL BETWEEN ONSET AND DEATH <i>9 hrs.</i> <i>unknown</i> <i>unknown</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>7-1948</i> , to <i>4-4-1956</i> that I last saw the deceased alive on <i>4-3-1956</i> , and that death occurred at <i>5:20 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John W. Robinson</i> M.D.		ADDRESS (Street, city or town, state) <i>1001 Eastern Ave.</i>	
PHYSICIAN'S NAME (Type) <i>JOHN W. ROBINSON, M.D.</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>4-6-56</i>		22b. DATE THEREOF <i>4-6-56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>mt Carmell</i>		22d. LOCATION (City, town, or county) (State) <i>Upper Marlboro Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry S. Washington</i>		ADDRESS <i>467 N st. N.W.</i>	
24a. REC'D BY REGISTRAR <i>4-6-56</i>		24b. REGISTRAR'S SIGNATURE <i>Carrie Campbell</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		M		35		JAN 5, 1921		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
Clerk		High School		Married		Catholic		White		White		Brown		Blue	
Cause of Death		Immediate Cause		Intermediate Cause		Underlying Cause		Manner of Death		Place of Death		Date of Death		Time of Death	
Myocardial Infarction		Coronary Atherosclerosis		Hypertension		Atherosclerosis		Natural		Home		JAN 14, 1956		10:15 AM	
Physician's Signature		Physician's Name		Physician's Address		Physician's City		Physician's State		Physician's Country		Physician's Zip		Physician's Phone	
[Signature]		JAMES EARL RAY		1000 ...		BALTIMORE		MD		21201		21201		21201	
Medical Examiner's Signature		Medical Examiner's Name		Medical Examiner's Address		Medical Examiner's City		Medical Examiner's State		Medical Examiner's Country		Medical Examiner's Zip		Medical Examiner's Phone	
[Signature]		JAMES EARL RAY		1000 ...		BALTIMORE		MD		21201		21201		21201	
Burial or Disposition		Burial or Disposition		Burial or Disposition		Burial or Disposition		Burial or Disposition		Burial or Disposition		Burial or Disposition		Burial or Disposition	
Buried		Buried		Buried		Buried		Buried		Buried		Buried		Buried	
Burial Place		Burial Place		Burial Place		Burial Place		Burial Place		Burial Place		Burial Place		Burial Place	
St. ...		St. ...		St. ...		St. ...		St. ...		St. ...		St. ...		St. ...	
Burial Date		Burial Date		Burial Date		Burial Date		Burial Date		Burial Date		Burial Date		Burial Date	
JAN 14, 1956		JAN 14, 1956		JAN 14, 1956		JAN 14, 1956		JAN 14, 1956		JAN 14, 1956		JAN 14, 1956		JAN 14, 1956	
Burial Time		Burial Time		Burial Time		Burial Time		Burial Time		Burial Time		Burial Time		Burial Time	
10:15 AM		10:15 AM		10:15 AM		10:15 AM		10:15 AM		10:15 AM		10:15 AM		10:15 AM	
Burial Name		Burial Name		Burial Name		Burial Name		Burial Name		Burial Name		Burial Name		Burial Name	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
Burial Address		Burial Address		Burial Address		Burial Address		Burial Address		Burial Address		Burial Address		Burial Address	
1000 ...		1000 ...		1000 ...		1000 ...		1000 ...		1000 ...		1000 ...		1000 ...	
Burial City		Burial City		Burial City		Burial City		Burial City		Burial City		Burial City		Burial City	
BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
Burial State		Burial State		Burial State		Burial State		Burial State		Burial State		Burial State		Burial State	
MD		MD		MD		MD		MD		MD		MD		MD	
Burial Country		Burial Country		Burial Country		Burial Country		Burial Country		Burial Country		Burial Country		Burial Country	
UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES		UNITED STATES	
Burial Zip		Burial Zip		Burial Zip		Burial Zip		Burial Zip		Burial Zip		Burial Zip		Burial Zip	
21201		21201		21201		21201		21201		21201		21201		21201	
Burial Phone		Burial Phone		Burial Phone		Burial Phone		Burial Phone		Burial Phone		Burial Phone		Burial Phone	
21201		21201		21201		21201		21201		21201		21201		21201	

BUREAU V. S.

APR 9, 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04306

4367

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>D.C.</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glenn Dale (RURAL)</u> LENGTH OF STAY (in this place) <u>20 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u> 478-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glenn Dale Hospital</u>		STREET ADDRESS (If rural, give location) <u>415 - 4th St., N.W.</u>	
3. NAME OF DECEASED (Type or Print) <u>EDMUND</u>	(First) <u>M</u> (Middle) <u>CLARK</u> (Last)	4. DATE OF DEATH	(Month) <u>4</u> (Day) <u>23</u> (Year) <u>1956</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>7/27/68</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE last birthday <u>87 yrs.</u>
13. FATHER'S NAME <u>Montgomery Clark</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Decedent</u>		14. MOTHER'S MAIDEN NAME <u>Mary Freeman</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
4290 Immediate cause (a) <u>Arteriosclerotic and Hypertensive Heart Disease</u>		6 yrs
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>002X</u>		
II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death. <u>Pulmonary Tuberculosis</u>		5 yrs 10 mos
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office hldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-26, 1956, to 4-23, 1956, that I last saw the deceased alive on 4-23, 1956, and that death occurred at 6:35 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Daniel Lee Pincane

M.D.,

Glenn Dale Hospital
Glenn Dale, Maryland

4/23/56

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>	<u>4/24/56</u>	<u>District of Columbia</u>	<u>Washington</u>	<u>D.C.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		
<u>4/24/56</u>	<u>Glenn Dale</u>	<u>Daniel Lee Pincane M.D.</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 27 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4319

CERTIFICATE OF DEATH

04308

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly		c. LENGTH OF STAY IN TB 3 days Ritchie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gen Hosp.		d. STREET ADDRESS 6697 Whitehouse Rd. S.E.	
3. NAME OF DECEASED (Type or print) Elizabeth S. Coffren		4. DATE OF DEATH April 1 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-2-15
9. AGE (In years lost birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME J. S. Cage		14. MOTHER'S MAIDEN NAME Edna M. Brady	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Edward L. Coffren		Address 6697 Whitehouse Rd., S.E. Washington 27, D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary metastasis DUE TO (c) Carcinoma of breast PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-29, 1956, to 4-1, 1956, that I last saw the deceased alive on 4-1, 1956, and that death occurred at 6:20 p. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald W. Mitchell		ADDRESS (Street, city or town, state) M.D. 1746 1st NE Washington D.C. 4-2-56	
PHYSICIAN'S NAME (Type) Donald Mitchell, M.D.		DATE SIGNED	
22a. BURIAL CREMATION, REMOVA (Specify) Burial		22b. DATE THEREOF 4/5/56	
22c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		22d. LOCATION (City, town, or county) (State) Forestville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funerary Home		ADDRESS 174	
24a. REC'D BY REGISTRAR DATE 4/5/56		24b. REGISTRAR'S SIGNATURE Amanda L. Lounney	

CERTIFICATE OF DEATH

6512

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
RACE		EDUCATION		OCCUPATION		MARRIAGE	
PLACE OF BIRTH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF INTERMENT		DATE OF INTERMENT	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
RACE		EDUCATION		OCCUPATION		MARRIAGE	
PLACE OF BIRTH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF INTERMENT		DATE OF INTERMENT	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	

BUREAU V. S.

APR 9 1956

RECEIVED

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
RACE		EDUCATION		OCCUPATION		MARRIAGE	
PLACE OF BIRTH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF INTERMENT		DATE OF INTERMENT	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> c. LENGTH OF STAY IN 1b <u>22 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp</u> e. STREET ADDRESS <u>Prince Georges Hosp</u> f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>																							
3. NAME OF DECEASED (Type or print) <u>Infant</u>		4. DATE OF DEATH Month <u>4</u> - Day <u>2</u> - Year <u>1956</u>		5. SEX <u>Female</u>																							
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-12-56</u>																							
9. AGE (In years last birthday) <u>3</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td><u>31</u></td> <td><u>31</u></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<u>31</u>	<u>31</u>			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td colspan="2">10b. KIND OF BUSINESS OR INDUSTRY</td> <td colspan="2">11. BIRTHPLACE (State or foreign country)</td> <td colspan="2">12. CITIZEN OF WHAT COUNTRY?</td> </tr> <tr> <td colspan="2"></td> <td colspan="2"><u>Maryland</u></td> <td colspan="2"><u>U S G</u></td> </tr> </table>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				<u>Maryland</u>		<u>U S G</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.																									
Months	Days	Hours	Min.																								
<u>31</u>	<u>31</u>																										
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?																							
		<u>Maryland</u>		<u>U S G</u>																							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>Elizabeth B. Cole</u>																							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u>																							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory collapse</u> DUE TO <u>Asphyxial Bronchospasm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)																											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital fixation of vocal cord (left)</u>																											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.																									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.																									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																							
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																											
ACTUAL SIGNATURE <u>John J. Maloney</u>		EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Apr. 3, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chesley M.F.</u>																							
22d. LOCATION (City, town, or county) (State) <u>Chesley Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>William W. ...</u>																									
24a. REC'D BY REGISTRAR <u>DATE 3/7/56</u>		24b. REGISTRAR'S SIGNATURE <u>Wanda Downey</u>																									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

207724445

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Enter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04309 231
Reg. Dist. No.

4320

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>				d. STREET ADDRESS <u>2809 Crest Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Marquis L. Collard, Jr.</u>				4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/5/95</u>		9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>56</u> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Marquis L. Collard, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Clara M. Wish</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Sadie M. Collard</u> Address <u>2809 Crest Ave. Chesley, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal failure</u> 180X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Hypertension - kidneys</u> DUE TO (c) <u>Unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/16</u> , 1956, to <u>4/24</u> , 1956, that I last saw the deceased alive on <u>4/24</u> , 1956, and that death occurred at <u>5:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.				ADDRESS (Street, city or town, state) <u>3404 Chesley, Md.</u> DATE SIGNED <u>4/24/56</u>			
PHYSICIAN'S NAME (Type) <u>John Kehoe</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/27/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR <u>4/26/56</u>		24b. REGISTRAR'S SIGNATURE <u>Shirley Downey</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 65		SEX Male		RACE White		DATE OF BIRTH 1890		PLACE OF BIRTH Maryland	
MARRIAGE Married		DATE OF MARRIAGE 1915		NAME OF SPOUSE Mary H. Harris		DATE OF DEATH 1956		PLACE OF DEATH Baltimore, Maryland		CAUSE OF DEATH Heart Disease	
OCCUPATION Retired		DATE OF OCCUPATION 1950		NAME OF EMPLOYER U.S. Post Office		DATE OF DEATH 1956		PLACE OF DEATH Baltimore, Maryland		CAUSE OF DEATH Heart Disease	
EDUCATION High School		DATE OF EDUCATION 1910		NAME OF SCHOOL St. Ann's School		DATE OF DEATH 1956		PLACE OF DEATH Baltimore, Maryland		CAUSE OF DEATH Heart Disease	
RELIGION Catholic		DATE OF RELIGION 1910		NAME OF CHURCH St. Ann's Church		DATE OF DEATH 1956		PLACE OF DEATH Baltimore, Maryland		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		DATE OF MANNER OF DEATH 1956		NAME OF PHYSICIAN Dr. J. H. Harris		DATE OF DEATH 1956		PLACE OF DEATH Baltimore, Maryland		CAUSE OF DEATH Heart Disease	
DATE OF DEATH 1956		PLACE OF DEATH Baltimore, Maryland		CAUSE OF DEATH Heart Disease		DATE OF DEATH 1956		PLACE OF DEATH Baltimore, Maryland		CAUSE OF DEATH Heart Disease	

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APR 30 1956
BUREAU V. S.

THIS CERTIFICATE IS VALID FOR THE PURPOSE OF OBTAINING A PASSPORT ONLY. IT IS NOT VALID FOR OTHER PURPOSES. IT IS THE POLICY OF THE DEPARTMENT OF HEALTH TO MAINTAIN THE ACCURACY OF THE RECORDS. IT IS THE POLICY OF THE DEPARTMENT OF HEALTH TO MAINTAIN THE ACCURACY OF THE RECORDS.

4321

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EUGENE Leland Memorial</u>		d. STREET ADDRESS <u>4717 Riverdale Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>IRENE BONNER CRISER</u>		4. DATE OF DEATH Month Day Year <u>APRIL 6 1956</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-10-05</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REGISTERED NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Flemming Gam</u>		14. MOTHER'S MAIDEN NAME <u>MARY VIRGINIA BONNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>233-34-6333</u>	
17. INFORMANT <u>taken from Hospital Records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphoma sarcoma</u> 200.1 DUE TO <u>Both general metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> , 19 <u>57</u> , to <u>APR 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>APR 6</u> , 19 <u>56</u> , and that death occurred at <u>1:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L W Malin</u> M.D.		DATE SIGNED <u>APR 6 1956</u>	
PHYSICIAN'S NAME (Type) <u>L. W. Malin</u>		Address <u>Riverdale, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>		22b. DATE THEREOF <u>4/7/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Clifton Forge</u>		22d. LOCATION (City, town, or county) (State) <u>Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gaschard</u>		ADDRESS <u>1420 14th St NW</u>	
24a. REC'D BY REGISTRAR <u>April 7 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. J. S. Severe</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
JAMES EARL RAY		MALE		35	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
APRIL 4, 1968		MEMPHIS, TENNESSEE		SHOOTING	
HUSBAND		WIFE		CHILDREN	
NONE		NONE		NONE	
BIRTH DATE		BIRTH PLACE		EDUCATION	
JANUARY 10, 1933		MOBILE, ALABAMA		HIGH SCHOOL	
OCCUPATION		MILITARY SERVICE		RELIGION	
MEMBER OF CONGRESS		ARMY		METHODIST	
DATE OF BIRTH		DATE OF DEATH		DATE OF BURIAL	
JAN 10 1933		APR 4 1968		APR 4 1968	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE		DATE		DATE	
APR 4 1968		APR 4 1968		APR 4 1968	

BUREAU V. 2

APR 10 1956

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 9 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: When this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04312

4323

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Chesley Rd.</u>				c. LENGTH OF STAY IN 1b <u>11 hrs.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4711 Ecomseh St.</u>				d. STREET ADDRESS <u>College Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>Daniels</u> Middle <u>Samuel</u> Last				4. DATE OF DEATH <u>April 11,</u> 19 <u>56</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 6, 1870</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Buildings</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Francis Daniels</u>				14. MOTHER'S MAIDEN NAME <u>Clara Ricardi</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT <u>Statistic Card</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac tamponade</u> <u>420.1</u> DUE TO <u>Myocardial infarction rupture</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerotic heart disease</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>1 week</u> <u>?</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4-10-56</u> , to <u>4-11-56</u> , that I last saw the deceased alive on <u>4-10-56</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. L. Etienne</u> M.D. <u>4713 Parkway Bel</u>				DATE SIGNED <u>4-12-56</u>			
PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u>				<u>College Park, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/11/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Beltville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>4/14/56</u>		24b. REGISTRAR'S SIGNATURE <u>Almanda Downey</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>		4. DATE OF DEATH <i>APR 15 1956</i>	
5. PLACE OF DEATH <i>HOME</i>		6. CITY <i>BALTIMORE</i>		7. COUNTY <i>JOHNS HOPKINS</i>		8. STATE <i>MARYLAND</i>	
9. OCCUPATION <i>ENGINEER</i>		10. CAUSE OF DEATH <i>HEART DISEASE</i>		11. MANNER OF DEATH <i>NATURAL</i>		12. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
13. SIGNATURE OF DECEASED <i>[Signature]</i>		14. SIGNATURE OF WITNESS <i>[Signature]</i>		15. SIGNATURE OF CLERK <i>[Signature]</i>		16. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
17. SIGNATURE OF DECEASED <i>[Signature]</i>		18. SIGNATURE OF WITNESS <i>[Signature]</i>		19. SIGNATURE OF CLERK <i>[Signature]</i>		20. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
21. SIGNATURE OF DECEASED <i>[Signature]</i>		22. SIGNATURE OF WITNESS <i>[Signature]</i>		23. SIGNATURE OF CLERK <i>[Signature]</i>		24. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
25. SIGNATURE OF DECEASED <i>[Signature]</i>		26. SIGNATURE OF WITNESS <i>[Signature]</i>		27. SIGNATURE OF CLERK <i>[Signature]</i>		28. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
29. SIGNATURE OF DECEASED <i>[Signature]</i>		30. SIGNATURE OF WITNESS <i>[Signature]</i>		31. SIGNATURE OF CLERK <i>[Signature]</i>		32. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
33. SIGNATURE OF DECEASED <i>[Signature]</i>		34. SIGNATURE OF WITNESS <i>[Signature]</i>		35. SIGNATURE OF CLERK <i>[Signature]</i>		36. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
37. SIGNATURE OF DECEASED <i>[Signature]</i>		38. SIGNATURE OF WITNESS <i>[Signature]</i>		39. SIGNATURE OF CLERK <i>[Signature]</i>		40. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
41. SIGNATURE OF DECEASED <i>[Signature]</i>		42. SIGNATURE OF WITNESS <i>[Signature]</i>		43. SIGNATURE OF CLERK <i>[Signature]</i>		44. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
45. SIGNATURE OF DECEASED <i>[Signature]</i>		46. SIGNATURE OF WITNESS <i>[Signature]</i>		47. SIGNATURE OF CLERK <i>[Signature]</i>		48. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
49. SIGNATURE OF DECEASED <i>[Signature]</i>		50. SIGNATURE OF WITNESS <i>[Signature]</i>		51. SIGNATURE OF CLERK <i>[Signature]</i>		52. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
53. SIGNATURE OF DECEASED <i>[Signature]</i>		54. SIGNATURE OF WITNESS <i>[Signature]</i>		55. SIGNATURE OF CLERK <i>[Signature]</i>		56. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
57. SIGNATURE OF DECEASED <i>[Signature]</i>		58. SIGNATURE OF WITNESS <i>[Signature]</i>		59. SIGNATURE OF CLERK <i>[Signature]</i>		60. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
61. SIGNATURE OF DECEASED <i>[Signature]</i>		62. SIGNATURE OF WITNESS <i>[Signature]</i>		63. SIGNATURE OF CLERK <i>[Signature]</i>		64. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
65. SIGNATURE OF DECEASED <i>[Signature]</i>		66. SIGNATURE OF WITNESS <i>[Signature]</i>		67. SIGNATURE OF CLERK <i>[Signature]</i>		68. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
69. SIGNATURE OF DECEASED <i>[Signature]</i>		70. SIGNATURE OF WITNESS <i>[Signature]</i>		71. SIGNATURE OF CLERK <i>[Signature]</i>		72. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
73. SIGNATURE OF DECEASED <i>[Signature]</i>		74. SIGNATURE OF WITNESS <i>[Signature]</i>		75. SIGNATURE OF CLERK <i>[Signature]</i>		76. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
77. SIGNATURE OF DECEASED <i>[Signature]</i>		78. SIGNATURE OF WITNESS <i>[Signature]</i>		79. SIGNATURE OF CLERK <i>[Signature]</i>		80. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
81. SIGNATURE OF DECEASED <i>[Signature]</i>		82. SIGNATURE OF WITNESS <i>[Signature]</i>		83. SIGNATURE OF CLERK <i>[Signature]</i>		84. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
85. SIGNATURE OF DECEASED <i>[Signature]</i>		86. SIGNATURE OF WITNESS <i>[Signature]</i>		87. SIGNATURE OF CLERK <i>[Signature]</i>		88. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
89. SIGNATURE OF DECEASED <i>[Signature]</i>		90. SIGNATURE OF WITNESS <i>[Signature]</i>		91. SIGNATURE OF CLERK <i>[Signature]</i>		92. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
93. SIGNATURE OF DECEASED <i>[Signature]</i>		94. SIGNATURE OF WITNESS <i>[Signature]</i>		95. SIGNATURE OF CLERK <i>[Signature]</i>		96. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
97. SIGNATURE OF DECEASED <i>[Signature]</i>		98. SIGNATURE OF WITNESS <i>[Signature]</i>		99. SIGNATURE OF CLERK <i>[Signature]</i>		100. SIGNATURE OF REGISTRAR <i>[Signature]</i>	

BUREAU V. S.

APR 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4324 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04313

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>Transient</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hosp.</u>				d. STREET ADDRESS <u>1615 - 12th, St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>James</u> Last <u>Dawson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 26, 1934</u>	
9. AGE (In years last birthday) <u>22</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car Washer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garage</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dell Dawson</u>				14. MOTHER'S MAIDEN NAME <u>Daisy Viola Thurston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Daisy V. Dawson</u> <u>1455 - T - St. N.W. Washington D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemoorrhage and shock</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture of skull and pelvis</u> (c), stating the underlying cause lost. DUE TO <u> </u> </p> </div> <div style="width: 35%; border-left: 1px solid black; padding-left: 5px;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u> </u></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of an automobile in collision with taxi and tree</u>					
20c. TIME OF INJURY Month, Day, Year <u>12-15-56</u> <u>4-19</u> 19 <u>56</u> Hour <u> </u> a.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Ex Street</u>		20f. (City or town) (County) (State) <u>Oakland, Pr. Georges, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John J. Maloney</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John T. Maloney</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 19, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>4601 Benning Rd. N.E. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John & Jenkins</u>				ADDRESS <u>1702 12th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>4/23/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Manda Horney</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, state execution of the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF JURY		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

BUREAU V. 8.

APR 24 1956

RECEIVED

4307

CERTIFICATE OF DEATH

04314

Reg. Dist. No. 245

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rogers Hgts. Hyattsville		c. LENGTH OF STAY IN 1b 10 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5300 Gallatin Street		d. STREET ADDRESS 5300 Gallatin Street	
3. NAME OF DECEASED (Type or print) Junious C Dollar		4. DATE OF DEATH April 20, 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 22, 1897
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during life, or occupation, even if retired) Bus Driver		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ashley A. Dollar		14. MOTHER'S MAIDEN NAME Sudie (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Eva F. Dollar, 5300 Gallatin St. Riverdale, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident 962X DUE TO A-V aneurysm due to old gun shot wound 10+ YRS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-9, 1956, to 4-20, 1956, that I last saw the deceased alive on Apr. 20, 1956, and that death occurred at 9:56 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Arnold A. Lear M.D. 4314 Gallatin St. 4-21-56 PHYSICIAN'S NAME (Type) ARNOLD A. LEAR Hyattsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/23/1956	22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cem.	22d. LOCATION (City, town, or county) (State) Suitland, Pr. Geo. Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE April 23, 1956	
		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe Deputy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Form 100-10 (Rev. 1-25-56)

1. NAME (Last, first, middle initial)
2. DATE OF BIRTH (Month, day, year)
3. SEX (M, F)
4. RACE (White, Negro, Other)
5. HEIGHT (Feet, inches)
6. WEIGHT (Pounds)
7. EYES (Blue, Brown, Green, Gray, Other)
8. HAIR (Black, Brown, Blond, Red, Other)
9. COMPLEXION (Fair, Ruddy, Olive, Other)
10. BLOOD TYPE (A, B, AB, O, Rh)
11. SOCIAL SECURITY NUMBER
12. MARITAL STATUS (Single, Married, Divorced, Widowed)
13. OCCUPATION
14. EDUCATION (High School, College, Graduate)
15. RELIGION
16. SIGNATURE
17. DATE

RECEIVED
APR 24 1956
BUREAU V. S.

4325

CERTIFICATE OF DEATH

Reg. Dist. No.

MEDICAL CERTIFICATION

BUREAU A.

MAY 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4368

CERTIFICATE OF DEATH

04316

Reg. Dist. No. 232

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges'			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. #5				d. STREET ADDRESS Rt. #5			
3. NAME OF DECEASED (Type or print) First Margaret Middle R. Last Early				4. DATE OF DEATH Month 4 Day 4 Year 1956			
5. SEX Female MALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 7, 1886	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 10 Days 3		IF UNDER 24 HRS. Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Henry Robinson				14. MOTHER'S MAIDEN NAME Amanda Baden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Helen Straub - Address Brandywine, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLI DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CA OF LIVER DUE TO (c) CA OF COLON						INTERVAL BETWEEN ONSET AND DEATH 2 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2NDARY ANEMIA						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from MAY 1947 to APRIL 4, 1956 that I last saw the deceased alive on APRIL 3, 1956 , and that death occurred at 5:54 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Alfred R. Lapin M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Clinical Medical Center Clinical, Maryland			
PHYSICIAN'S NAME (Type) ALFRED R. LAPIN, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/7/56		22c. NAME OF CEMETERY OR CREMATORY Washington National Cem.		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. ADDRESS Upper Marlboro, Maryland				24a. REC'D BY REGISTRAR DATE 4/9/56		24b. REGISTRAR'S SIGNATURE John F. Danner	

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04317

Reg. Dist. No. 2402

4369

1. PLACE OF DEATH:

County Prince GeorgesCity or town Maryland Park
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 43

Hospital, institution, or street address where death occurred:

6519 Buchanan St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Pr. GeosCity or town Maryland Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 6519 Buchanan St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Elizabeth Gertrude
Elizabeth Mary Effinger

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband

George William Effinger

7. Birth date of deceased (mo., day, yr.)

November 6th 18846. (c) If alive, give age 73 years

8. AGE:

Years 71

Months

Days

If less than one day

hrs. min.

9. Birthplace

Washington D.C.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own Home

MOTHER FATHER

12. Name

W^m Thomas Lucas

13. Birthplace

Washington D.C.

14. Maiden name

Mary Ellen Rhodes

15. Birthplace

Baltimore Md.

16. Informant

Geo. W^m Effinger Jr Md Park

Address

6523 Buchanan St Maryland

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

4/26/56
(month) (day) (year)

Cemetery or crematory

Burial

Location

St. Paul's, Md.

18. Funeral director

Lee Funeral Home

Address

Wash. D.C.

19.

4-24
(Date rec'd by registrar)

19

56
Carie F. Campbell

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 23 19 56 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 29 19 48 to April 23 19 56and that I last saw h^er alive on April 23 19 56Immediate cause of death Uremia

DURATION

4 mthsDue to Chronic nephritis6 yrsDue to Generalized arteriosclerosis7 yrsOther conditions Diabetes Mellitus7 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Diet Ritchie MD

M. D. or other

Address 7005 Ritchie Rd SEDate signed 4/23/56Wash 27 D.C.

RECEIVED

APR 27 1956

BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4308

CERTIFICATE OF DEATH

Reg. Dist. No.

04318
345

1. PLACE OF DEATH a. COUNTY <i>Pr. Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind</i> b. COUNTY <i>Pr. Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Highlyvely Md</i>		c. LENGTH OF STAY IN 1b <i>1 yr</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3900 Hamilton</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>George SHRYOCK Eggers</i>		4. DATE OF DEATH Month Day Year <i>APR 9 1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-10-05</i>
9. AGE (In years last birthday) <i>50</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Univ. of Md</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Univ. of Md</i>	
11. BIRTHPLACE (State or foreign country) <i>Ind.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>HENRY EGGERS</i>		14. MOTHER'S MAIDEN NAME <i>ANNIE THOMPSON</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-09-0433</i>	
17. INFORMANT Address <i>same add</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 42010 DUE TO <i>Arterio-sclerotic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Dissecting Aortic Aneurysm</i> (c) <i>Dissecting Aortic Aneurysm</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>4-4</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 26, 1956</i> to <i>April 3, 1956</i> , that I last saw the deceased alive on <i>4-9-56</i> , 19 <i>56</i> , and that death occurred at <i>3 pm</i> M from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W.L. Etienne</i> M.D.		ADDRESS (Street, city or town, state) <i>4713 - Tremont St College Park, Md</i>	
PHYSICIAN'S NAME (Type) <i>W.L. ETIENNE</i>		DATE SIGNED <i>April 11 1956</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>4/10/1956</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>BAK HILL CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>LONACONING ALLEGANY Co, MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. CHAMBERS Co - RIVERDALE, Md</i>		24a. REC'D BY REGISTRAR <i>April 11 1956</i>	
24b. REGISTRAR'S SIGNATURE <i>Mrs. Jas. Severel</i>		24c. REGISTRAR'S SIGNATURE <i>defunct</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>George SHROCK</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>April 13, 1956</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
10. SIGNATURE OF REGISTRAR <i>[Signature]</i>		11. SIGNATURE OF WITNESSES <i>[Signature]</i>		12. SIGNATURE OF DECEASED <i>[Signature]</i>	
13. SIGNATURE OF FUNERAL HOME <i>[Signature]</i>		14. SIGNATURE OF BURIAL PLACE <i>[Signature]</i>		15. SIGNATURE OF OTHER <i>[Signature]</i>	
16. SIGNATURE OF OTHER <i>[Signature]</i>		17. SIGNATURE OF OTHER <i>[Signature]</i>		18. SIGNATURE OF OTHER <i>[Signature]</i>	
19. SIGNATURE OF OTHER <i>[Signature]</i>		20. SIGNATURE OF OTHER <i>[Signature]</i>		21. SIGNATURE OF OTHER <i>[Signature]</i>	
22. SIGNATURE OF OTHER <i>[Signature]</i>		23. SIGNATURE OF OTHER <i>[Signature]</i>		24. SIGNATURE OF OTHER <i>[Signature]</i>	
25. SIGNATURE OF OTHER <i>[Signature]</i>		26. SIGNATURE OF OTHER <i>[Signature]</i>		27. SIGNATURE OF OTHER <i>[Signature]</i>	
28. SIGNATURE OF OTHER <i>[Signature]</i>		29. SIGNATURE OF OTHER <i>[Signature]</i>		30. SIGNATURE OF OTHER <i>[Signature]</i>	
31. SIGNATURE OF OTHER <i>[Signature]</i>		32. SIGNATURE OF OTHER <i>[Signature]</i>		33. SIGNATURE OF OTHER <i>[Signature]</i>	
34. SIGNATURE OF OTHER <i>[Signature]</i>		35. SIGNATURE OF OTHER <i>[Signature]</i>		36. SIGNATURE OF OTHER <i>[Signature]</i>	
37. SIGNATURE OF OTHER <i>[Signature]</i>		38. SIGNATURE OF OTHER <i>[Signature]</i>		39. SIGNATURE OF OTHER <i>[Signature]</i>	
40. SIGNATURE OF OTHER <i>[Signature]</i>		41. SIGNATURE OF OTHER <i>[Signature]</i>		42. SIGNATURE OF OTHER <i>[Signature]</i>	
43. SIGNATURE OF OTHER <i>[Signature]</i>		44. SIGNATURE OF OTHER <i>[Signature]</i>		45. SIGNATURE OF OTHER <i>[Signature]</i>	
46. SIGNATURE OF OTHER <i>[Signature]</i>		47. SIGNATURE OF OTHER <i>[Signature]</i>		48. SIGNATURE OF OTHER <i>[Signature]</i>	
49. SIGNATURE OF OTHER <i>[Signature]</i>		50. SIGNATURE OF OTHER <i>[Signature]</i>		51. SIGNATURE OF OTHER <i>[Signature]</i>	
52. SIGNATURE OF OTHER <i>[Signature]</i>		53. SIGNATURE OF OTHER <i>[Signature]</i>		54. SIGNATURE OF OTHER <i>[Signature]</i>	
55. SIGNATURE OF OTHER <i>[Signature]</i>		56. SIGNATURE OF OTHER <i>[Signature]</i>		57. SIGNATURE OF OTHER <i>[Signature]</i>	
58. SIGNATURE OF OTHER <i>[Signature]</i>		59. SIGNATURE OF OTHER <i>[Signature]</i>		60. SIGNATURE OF OTHER <i>[Signature]</i>	
61. SIGNATURE OF OTHER <i>[Signature]</i>		62. SIGNATURE OF OTHER <i>[Signature]</i>		63. SIGNATURE OF OTHER <i>[Signature]</i>	
64. SIGNATURE OF OTHER <i>[Signature]</i>		65. SIGNATURE OF OTHER <i>[Signature]</i>		66. SIGNATURE OF OTHER <i>[Signature]</i>	
67. SIGNATURE OF OTHER <i>[Signature]</i>		68. SIGNATURE OF OTHER <i>[Signature]</i>		69. SIGNATURE OF OTHER <i>[Signature]</i>	
70. SIGNATURE OF OTHER <i>[Signature]</i>		71. SIGNATURE OF OTHER <i>[Signature]</i>		72. SIGNATURE OF OTHER <i>[Signature]</i>	
73. SIGNATURE OF OTHER <i>[Signature]</i>		74. SIGNATURE OF OTHER <i>[Signature]</i>		75. SIGNATURE OF OTHER <i>[Signature]</i>	
76. SIGNATURE OF OTHER <i>[Signature]</i>		77. SIGNATURE OF OTHER <i>[Signature]</i>		78. SIGNATURE OF OTHER <i>[Signature]</i>	
79. SIGNATURE OF OTHER <i>[Signature]</i>		80. SIGNATURE OF OTHER <i>[Signature]</i>		81. SIGNATURE OF OTHER <i>[Signature]</i>	
82. SIGNATURE OF OTHER <i>[Signature]</i>		83. SIGNATURE OF OTHER <i>[Signature]</i>		84. SIGNATURE OF OTHER <i>[Signature]</i>	
85. SIGNATURE OF OTHER <i>[Signature]</i>		86. SIGNATURE OF OTHER <i>[Signature]</i>		87. SIGNATURE OF OTHER <i>[Signature]</i>	
88. SIGNATURE OF OTHER <i>[Signature]</i>		89. SIGNATURE OF OTHER <i>[Signature]</i>		90. SIGNATURE OF OTHER <i>[Signature]</i>	
91. SIGNATURE OF OTHER <i>[Signature]</i>		92. SIGNATURE OF OTHER <i>[Signature]</i>		93. SIGNATURE OF OTHER <i>[Signature]</i>	
94. SIGNATURE OF OTHER <i>[Signature]</i>		95. SIGNATURE OF OTHER <i>[Signature]</i>		96. SIGNATURE OF OTHER <i>[Signature]</i>	
97. SIGNATURE OF OTHER <i>[Signature]</i>		98. SIGNATURE OF OTHER <i>[Signature]</i>		99. SIGNATURE OF OTHER <i>[Signature]</i>	
100. SIGNATURE OF OTHER <i>[Signature]</i>		101. SIGNATURE OF OTHER <i>[Signature]</i>		102. SIGNATURE OF OTHER <i>[Signature]</i>	

RECEIVED
APR 13 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4326 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04319

Reg. Dist. No. 231

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2½ hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 4716 Powder Mill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANCIS Middle CLEVELAND Last FLORA				4. DATE OF DEATH Month April Day 4th , Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 10th 1895		9. AGE (In years last birthday) 61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer		10b. KIND OF BUSINESS OR INDUSTRY Storage Business		11. BIRTHPLACE (State or foreign country) Highland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick Flora				14. MOTHER'S MAIDEN NAME Sarah Hinton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Edith M. Jones, 4716 Powder Mill Rd., Beltsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular Renal Disease DUE TO (c)</p> </div> <div style="width: 35%; text-align: right;"> <p>INITIAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i> M.D. EXAMINER'S NAME (Type) John T. Maloney				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Apr. 7, 1956		22c. NAME OF CEMETERY OR CREMATORY St. John's Ch. Cemetery Forest Glen, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., Riverdale, Md.				24a. REC'D BY REGISTRAR 4/6/56		24b. REGISTRAR'S SIGNATURE <i>Amanda D. Jones</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		Male		White		April 4, 1968		Baltimore, Maryland	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM EXAMINATION	
1111 North Enoch Avenue, Baltimore, Md.		None		Suicide by gunshot wound of the chest		Suicide		None		None	
FATHER		MOTHER		SISTER		BROTHER		PREVIOUS ILLNESS		PREVIOUS SURGERY	
James Earl Ray, Sr.		Mary Elizabeth Ray		None		None		None		None	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		RELIGION		MARITAL STATUS		DATE OF MARRIAGE	
April 1, 1933		Baltimore, Md.		High School		Catholic		Single		None	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM EXAMINATION	
April 4, 1968		Baltimore, Md.		Suicide by gunshot wound of the chest		Suicide		None		None	
FATHER		MOTHER		SISTER		BROTHER		PREVIOUS ILLNESS		PREVIOUS SURGERY	
James Earl Ray, Sr.		Mary Elizabeth Ray		None		None		None		None	

BUREAU V. S.

APR 9 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4327 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04320

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 76 Leland Memorial Hospital				d. STREET ADDRESS Aitcherson Road			
3. NAME OF DECEASED (Type or print) First John Middle Howard Last Flora				4. DATE OF DEATH Month April Day 1 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1890		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Sand & Gravel		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Flora				14. MOTHER'S MAIDEN NAME Sarah Hinton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-16-2593		17. INFORMANT Noah Thomas, Same address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 910.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fractured ribs with pneumothorax, and fractured skull. DUE TO (c) _____</p> </div> <div style="width: 35%; border: 1px solid black; padding: 5px;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____</p>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) A tree fell on deceased while he was at work in woods.					
20c. TIME OF INJURY Month, Day, Year 1.00 P.M. 3-30- 1956	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) woods		20f. (City or town) Beltsville, Pr. Geo. Md.		20g. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/1956		22c. NAME OF CEMETERY OR CREMATORY Lvy Hill Cemetery		22d. LOCATION (City, town, or county) (State) Laurel, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.				24a. REC'D BY REGISTRAR April 3, 1956		24b. REGISTRAR'S SIGNATURE James Severe	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed the day following the death, and the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4328

CERTIFICATE OF DEATH

04321

Reg. Dist. No. 237

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg				c. LENGTH OF STAY IN 1b 83 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) 4323 Baltimore Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edward First Middle Last GASCH				4. DATE OF DEATH April Month 13 Day 19 Year 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 March 1873	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Undertaker				10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Francis Gasch				14. MOTHER'S MAIDEN NAME Sophie Schram			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Francie E. Gasch (Son) Address Same add. as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Tumor of the lungs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 18 Mar. 1956 to Apr. 13, 1956 , that I last saw the deceased alive on 12 , and that death occurred at M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE F. Gasch's Sons				DATE SIGNED 5/1/56 30118 Baltimore Ave. Hyattsville			
PHYSICIAN'S NAME (Type) A. H. Dani M.D. 5118 Baltimore Ave. Hyattsville							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 4/16/56		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Colmar Manor Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Maryland				24a. REC'D BY REGISTRAR 4/14/56		24b. REGISTRAR'S SIGNATURE Wanda D. Dwyer	

CERTIFICATE OF DEATH

1938

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

FILE NO.

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		12-1-28		MOBILE, ALABAMA	
SEX		AGE		MARRIAGE	
Male		9 years, 10 months		Never married	
RACE		COLOR		RELIGION	
White		White		Methodist	
EDUCATION		OCCUPATION		CAUSE OF DEATH	
High School		Student		Diphtheria	
MOTHER'S NAME		FATHER'S NAME		DATE OF DEATH	
MRS. J. EARL RAY		J. EARL RAY		12-1-38	
MOTHER'S RESIDENCE		FATHER'S RESIDENCE		PLACE OF DEATH	
Mobile, Ala.		Mobile, Ala.		Mobile, Ala.	

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		12-1-28		MOBILE, ALABAMA	
SEX		AGE		MARRIAGE	
Male		9 years, 10 months		Never married	
RACE		COLOR		RELIGION	
White		White		Methodist	
EDUCATION		OCCUPATION		CAUSE OF DEATH	
High School		Student		Diphtheria	
MOTHER'S NAME		FATHER'S NAME		DATE OF DEATH	
MRS. J. EARL RAY		J. EARL RAY		12-1-38	
MOTHER'S RESIDENCE		FATHER'S RESIDENCE		PLACE OF DEATH	
Mobile, Ala.		Mobile, Ala.		Mobile, Ala.	

BUREAU V. S.

APR 20 1956

RECEIVED

NAME OF DECEASED	DATE OF BIRTH	PLACE OF BIRTH
JAMES EARL RAY	12-1-28	MOBILE, ALABAMA
SEX	AGE	MARRIAGE
Male	9 years, 10 months	Never married
RACE	COLOR	RELIGION
White	White	Methodist
EDUCATION	OCCUPATION	CAUSE OF DEATH
High School	Student	Diphtheria
MOTHER'S NAME	FATHER'S NAME	DATE OF DEATH
MRS. J. EARL RAY	J. EARL RAY	12-1-38
MOTHER'S RESIDENCE	FATHER'S RESIDENCE	PLACE OF DEATH
Mobile, Ala.	Mobile, Ala.	Mobile, Ala.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04322

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4314

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7417 Wildwood Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Richard K Geraghty</u>		4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-15-1903</u>
9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tax examiner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	11. BIRTHPLACE (State or foreign country) <u>New York State</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles R. Geraghty</u>		14. MOTHER'S MAIDEN NAME <u>Alice Sloan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Winifred W. Geraghty, same address</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive cardiovascular disease</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John T. Maloney</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 8, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-11-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Jr.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 10 1956</u>	
ADDRESS <u>317 Penna. Ave. S.E. Washington 3, D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>James Ryan</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

APR 10 1956

RECEIVED

4309

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Prince Georges</i>	MARYLAND	STATE <i>MD</i>	COUNTY <i>D. C.</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>15 Hyattsville</i>	LENGTH OF STAY (in this place) <i>10 mos</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Washington 11</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>6403 Ager Road</i>		STREET ADDRESS (If rural give location) <i>1366 Tewkesbury Place, N. W.</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>Michael Gertz</i>		DATE OF DEATH: <i>4 30 1956</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>	8. DATE OF BIRTH: <i>May 4 1955</i>
9. AGE last birthday		IF UNDER 1 YEAR	
<i>11 yrs.</i>		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
		<i>Washington DC</i>	
13. FATHER'S NAME: <i>Rubini Gertz</i>		14. MOTHER'S MAIDEN NAME: <i>Sophie Sherman</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>110</i>		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: <i>History on chart</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <i>Terminal bronchopneumonia</i>		<i>4 hr</i>
DUE TO		
ANTECEDENT CAUSE (B) <i>upper respiratory infection</i>		<i>1 day</i>
DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Mongolism</i>		<i>birth on</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *6/53*, 19*55*, to *4/30*, 19*56*, that I last saw the deceased alive on *4/30*, 19*56*, and that death occurred at *6:35* AM, from the causes and on the date stated above.

SIGNATURE *Thomas R. Christensen* ADDRESS *College Park, Md* DATE SIGNED *4/30/56*

23. BURIAL, CREMATION, REMOVAL (SPECIFY) *Burial* DATE THEREOF *Apr 30/56* NAME OF CEMETERY OR CREMATORY *Beth Shalom Cn* LOCATION (City, town, or county) (State) *Hillside Md*

DATE REC'D BY LOCAL REGISTRAR *Apr 30 1956 James Severy* REGISTRAR'S SIGNATURE *James Severy* 24. FUNERAL DIRECTOR ADDRESS *B Dargatzis & Co Wash. 10 DC*

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

May 1, 1956

Dear Sir:

I am pleased to inform you that

the following information has been received

from the Bureau of the Census:

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RECEIVED
MAY 1 1956
BUREAU V. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE, 18

04324

4370

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Heights		c. LENGTH OF STAY IN IB 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4408 Beechwood Rd		d. STREET ADDRESS 4408 Beechwood Road, .	
3. NAME OF DECEASED (Type or print) First Middle Last Sadie Gingell		4. DATE OF DEATH Month Day Year April 3, 19 56.	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 11, 1885
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME Samuel Leizear		14. MOTHER'S MAIDEN NAME Anna Padget	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT J. Earl Gingell		Address College Heights Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on 19 and that death occurred on 19, from the cause and on the date noted above.		ADDRESS (Street, city or town, state) DATE SIGNED 4/3/56	
ACTUAL SIGNATURE		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/5/56	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE April 7-56	
		24b. REGISTRAR'S SIGNATURE John D. Smith	

CERTIFICATE OF DEATH

BUREAU V. S.

APR 10 1956

RECEIVED

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF DEATH <i>April 5, 1956</i>	
5. PLACE OF DEATH <i>Home</i>		6. CAUSE OF DEATH <i>Heart Disease</i>		7. MANNER OF DEATH <i>Natural</i>		8. SIGNATURE OF DECEASED <i>John Doe</i>	
9. SIGNATURE OF WITNESS <i>John Doe</i>		10. SIGNATURE OF DECEASED <i>John Doe</i>		11. SIGNATURE OF DECEASED <i>John Doe</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF DECEASED <i>John Doe</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF DECEASED <i>John Doe</i>	
17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>		19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>	
21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF DECEASED <i>John Doe</i>		23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF DECEASED <i>John Doe</i>		27. SIGNATURE OF DECEASED <i>John Doe</i>		28. SIGNATURE OF DECEASED <i>John Doe</i>	
29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>John Doe</i>		31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF DECEASED <i>John Doe</i>	
33. SIGNATURE OF DECEASED <i>John Doe</i>		34. SIGNATURE OF DECEASED <i>John Doe</i>		35. SIGNATURE OF DECEASED <i>John Doe</i>		36. SIGNATURE OF DECEASED <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF DECEASED <i>John Doe</i>		39. SIGNATURE OF DECEASED <i>John Doe</i>		40. SIGNATURE OF DECEASED <i>John Doe</i>	
41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF DECEASED <i>John Doe</i>		43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF DECEASED <i>John Doe</i>	
45. SIGNATURE OF DECEASED <i>John Doe</i>		46. SIGNATURE OF DECEASED <i>John Doe</i>		47. SIGNATURE OF DECEASED <i>John Doe</i>		48. SIGNATURE OF DECEASED <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF DECEASED <i>John Doe</i>		51. SIGNATURE OF DECEASED <i>John Doe</i>		52. SIGNATURE OF DECEASED <i>John Doe</i>	
53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF DECEASED <i>John Doe</i>		55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF DECEASED <i>John Doe</i>	
57. SIGNATURE OF DECEASED <i>John Doe</i>		58. SIGNATURE OF DECEASED <i>John Doe</i>		59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF DECEASED <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF DECEASED <i>John Doe</i>		63. SIGNATURE OF DECEASED <i>John Doe</i>		64. SIGNATURE OF DECEASED <i>John Doe</i>	
65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF DECEASED <i>John Doe</i>		67. SIGNATURE OF DECEASED <i>John Doe</i>		68. SIGNATURE OF DECEASED <i>John Doe</i>	
69. SIGNATURE OF DECEASED <i>John Doe</i>		70. SIGNATURE OF DECEASED <i>John Doe</i>		71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF DECEASED <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF DECEASED <i>John Doe</i>		75. SIGNATURE OF DECEASED <i>John Doe</i>		76. SIGNATURE OF DECEASED <i>John Doe</i>	
77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF DECEASED <i>John Doe</i>		79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF DECEASED <i>John Doe</i>	
81. SIGNATURE OF DECEASED <i>John Doe</i>		82. SIGNATURE OF DECEASED <i>John Doe</i>		83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF DECEASED <i>John Doe</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF DECEASED <i>John Doe</i>		87. SIGNATURE OF DECEASED <i>John Doe</i>		88. SIGNATURE OF DECEASED <i>John Doe</i>	
89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF DECEASED <i>John Doe</i>		91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF DECEASED <i>John Doe</i>	
93. SIGNATURE OF DECEASED <i>John Doe</i>		94. SIGNATURE OF DECEASED <i>John Doe</i>		95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF DECEASED <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF DECEASED <i>John Doe</i>		99. SIGNATURE OF DECEASED <i>John Doe</i>		100. SIGNATURE OF DECEASED <i>John Doe</i>	

4329

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Georges General Hosp</u>		d. STREET ADDRESS <u>3719-Shepherd St</u>	
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>John</u> Last <u>Glanton</u>		4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/18/89</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Rochester, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Glanton</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Reagan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>325-01-2727</u>	
17. INFORMANT <u>Michael Glanton, Brother</u>		Address <u>3719-Shepherd St. Brentwood</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis Heart Disease</u> DUE TO (b) <u>10 years</u> DUE TO (c) <u>10 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> 19 <u>53</u> , to <u>April 22</u> 19 <u>56</u> that I last saw the deceased alive on <u>April 22</u> 19 <u>56</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm R. Gellin</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>3827-34th St Mt. Rainier Md</u> <u>23 April 56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/25/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malley's Funeral Home Inc.</u>		24a. REC'D BY REGISTRAR <u>4/23/56</u>	
ADDRESS <u>Mt. Rainier Md</u>		24b. REGISTRAR'S SIGNATURE <u>Manda Dourney</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 24 1956

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4371 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04326

Reg. Dist. No. 142

1. PLACE OF DEATH a. COUNTY <u>Pr. Georges'</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u>			c. LENGTH OF STAY IN 1b <u>Transient</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>In wooded area 1 mile South of Accokeek Intersection</u>				d. STREET ADDRESS <u>1135 Park Street, N. E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Neal</u> Middle <u>-</u> Last <u>Hadley</u>				4. DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>19 56</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/6/05</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver (Employed) Meat Packing</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Meat Packing</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Martin Hadley</u>				14. MOTHER'S MAIDEN NAME <u>Jane Murchinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Luevinia Hadley</u> <u>1135 Park Street, N.E. Washington, D. C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X acute congestive heart failure</u> </div> <div style="width: 30%;"> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) <u>Cardiovascular disease</u> </div> <div style="width: 30%;"> DUE TO (c) <u> </u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				DATE SIGNED <u>April 3, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>4/4/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stewart Funeral Home</u>		22d. LOCATION (City, town or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart Funeral Home</u>				24a. REC'D BY REGISTRAR <u>4-5-56</u>		24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the case should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

APR 9 1955

RECEIVED

4330

CERTIFICATE OF DEATH

Reg. Dist. No.

rtv

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Cheeverly -</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington - D.C. 47x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>17 Prince Geo. Gen. Hosp</u>			d. STREET ADDRESS <u>1419 - Sacramento Ave SE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>Hankoff</u> Last _____			4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 Dec. 1897</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>	
13. FATHER'S NAME <u>William Filtzer</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Benjamin Hankoff</u>		17. INFORMANT <u>- same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>auricular fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> (c) <u>Coronary Thrombosis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 days</u> <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>April 22, 1956</u> , to <u>April 24, 1956</u> , that I last saw the deceased alive on <u>April 24, 1956</u> , and that death occurred at <u>11:50 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Benjamin S. Miller</u>		ADDRESS (Street, city or town, state) <u>3824 34th Mt Palmer</u>		DATE SIGNED <u>April 25 1956</u>	
PHYSICIAN'S NAME (Type) <u>BENJAMIN S. MILLER</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>	<u>4-25-56</u>	<u>United Hebrew</u>		<u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u>		ADDRESS <u>2100 Eutaw Place</u>		24a. REC'D BY REGISTRAR <u>James Lewis</u>	
				24b. REGISTRAR'S SIGNATURE <u>James Lewis</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

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CAUSE OF DEATH

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BUREAU V. 1

APR 27 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G196 5-7-56 at

4331

CERTIFICATE OF DEATH

04328

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Chesley, Md.</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>77 Prince George's Gen. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ralph</u> First <u>Harris</u> Middle <u>Harris</u> Last <u>Harris</u>				4. DATE OF DEATH <u>April 21, 1956</u> Month <u>April</u> Day <u>21</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>M</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-13-00</u> 55 yrs.	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>17</u> Hours <u>55</u> Min.		IF UNDER 24 HRS. Months <u>5</u> Days <u>17</u> Hours <u>55</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salmon</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sea Co</u>			
11. BIRTHPLACE (State or foreign country) <u>Stolm Newfoundland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Isaac Harris</u>				14. MOTHER'S MAIDEN NAME <u>Anna Myer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>			
17. INFORMANT <u>Allie Harris</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Pulmonary Emboli</u> 420.1 DUE TO <u>Correlative Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Coronary Arteriosclerotic Heart Disease</u> (b) <u>Coronary Arteriosclerotic Heart Disease</u> (c) <u>Coronary Arteriosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>2 YEARS</u> <u>4 YEARS</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>April 19, 1956</u> , to <u>April 21, 1956</u> , that I last saw the deceased alive on <u>April 21, 1956</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel J. Sugar</u>				M.D. <u>Mr. Ranner</u> ADDRESS (Street, city or town, state) <u>Md.</u> DATE SIGNED <u>Apr 21, 1956</u>			
PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>4/23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>King David Co</u>		22d. LOCATION (City, town, or county) (State) <u>Fall Church Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. G. Gandy</u> ADDRESS <u>3501-14 25th St</u>				24a. REC'D BY REGISTRAR <u>April 24 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Amanda Bousley</u>			

BUREAU

APR 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

See: Birth Cert.

04330

4332

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pri. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Chesley Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beaver Heights</u>	
c. LENGTH OF STAY IN TB <u>2 days</u>		d. STREET ADDRESS <u>1702 Kenilworth Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>77 Prince Georges Gen. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First Middle Last		4. DATE OF DEATH <u>April</u> Month Day Year <u>9, 19 56</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 3, 1956</u>
9. AGE (In years last birthday) yrs. <u>6</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jones, Robert</u>		14. MOTHER'S MAIDEN NAME <u>Watts, Ruby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>761.5 Collapsed cord with anoxia</u> DUE TO (b) <u>Prematurity (2 lbs)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/9/56</u> , 19 <u>56</u> , to <u>4/9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/9</u> , 19 <u>56</u> , and that death occurred at <u>8:15</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas A. Christensen M.D.</u>		ADDRESS (Street, city or town, state) <u>College Park, Md</u> DATE SIGNED <u>4/9/56</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>April 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chesley Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W Penn</u> ADDRESS <u>501</u>		24a. REC'D BY REGISTRAR <u>DATE 5/2/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Wanda Downey</u>			

20773/1241

CERTIFICATE OF DEATH

PLACE IN BOXES		MARRIAGE	
1. Name of deceased		2. Date of death	
3. Sex		4. Age	
5. Race		6. Birth date	
7. Birth place		8. Date of birth	
9. Place of death		10. Cause of death	
11. Date of death		12. Time of death	
13. Place of death		14. Date of death	
15. Place of death		16. Date of death	
17. Place of death		18. Date of death	
19. Place of death		20. Date of death	
21. Place of death		22. Date of death	
23. Place of death		24. Date of death	
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27. Place of death		28. Date of death	
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95. Place of death		96. Date of death	
97. Place of death		98. Date of death	
99. Place of death		100. Date of death	

BUREAU V. E.

MAY 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4333

CERTIFICATE OF DEATH

04331

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PR. GEO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 RIVERDALE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 RIVERDALE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4713 OLIVER ST.				d. STREET ADDRESS 4713 OLIVER ST			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last EMILY BECK JONES				4. DATE OF DEATH Month Day Year APRIL 29. 1956			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT 20, 1894	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME BRYANT				14. MOTHER'S MAIDEN NAME GERTRUDE BRAY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NONE				16. SOCIAL SECURITY NO. —		17. INFORMANT Address WILLIAM R. JONES RIVERDALE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.9 CONGESTIVE HEART FAILURE DUE TO (b) GENERALIZED CARCINOMATOSIS DUE TO (c) 4 MONTHS. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from JAN 15, 1956 , to APR 29, 1956 , that I last saw the deceased alive on APR 29, 1956 , and that death occurred at 8:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel J. N. Sugar M.D.				ADDRESS (Street, city or town, state) 4300 KAYWOOD DR MT KAINIER MD DATE SIGNED APR 29, 1956			
PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/2/56		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		22d. LOCATION (City, town, or county) (State) SUITLAND MD	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS CO RIVERDALE MD ADDRESS				24a. REC'D BY REGISTRAR April 30 1956 Mrs. Jas. Severe		24b. REGISTRAR'S SIGNATURE	

RECEIVED
MAY 1 1954

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4334

CERTIFICATE OF DEATH

04332

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Chesley, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Chesley, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Gov. Hosp.		d. STREET ADDRESS 3024 Crest Ave.	
3. NAME OF DECEASED (Type or print) John M. Kehoe		4. DATE OF DEATH April 28, 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1948
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School boy		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME Kehoe, Matthew H.		14. MOTHER'S MAIDEN NAME Marguerite Badie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Matthew H. Kehoe, Father		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 550.1 Generalized peritonitis. Subhepatic abscess; shock DUE TO (b) Partial intestinal obstruction DUE TO (c) Ruptured vermiform appendix removed surgically on 11-11-56		INTERVAL BETWEEN ONSET AND DEATH 24 hours 48 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. f. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/10, 1956 to 4/28, 1956 that I last saw the deceased alive on 4/28, 1956, and that death occurred at 5 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Bayly		ADDRESS (Street, city or town, state) DATE SIGNED 1835 EYE N.W. WASH. D.C.	
PHYSICIAN'S NAME (Type) JOHN H. BAYLY			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/1/56	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home, Inc. 4000 RAINIER, MD.		24a. REC'D BY REGISTRAR DATE 5/1/56	
		24b. REGISTRAR'S SIGNATURE Amanda Dourney	

CERTIFICATE OF DEATH

1934

Page One

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. SIGNATURE OF DECEASED</p> <p>16. SIGNATURE OF WITNESS</p> <p>17. SIGNATURE OF PHYSICIAN</p> <p>18. SIGNATURE OF CORONER</p> <p>19. SIGNATURE OF JURY</p> <p>20. SIGNATURE OF JUDGE</p> <p>21. SIGNATURE OF CLERK</p> <p>22. SIGNATURE OF REGISTRAR</p> <p>23. SIGNATURE OF ASSISTANT REGISTRAR</p> <p>24. SIGNATURE OF CLERK</p> <p>25. SIGNATURE OF REGISTRAR</p> <p>26. SIGNATURE OF ASSISTANT REGISTRAR</p> <p>27. SIGNATURE OF CLERK</p> <p>28. SIGNATURE OF REGISTRAR</p> <p>29. SIGNATURE OF ASSISTANT REGISTRAR</p> <p>30. SIGNATURE OF CLERK</p> <p>31. SIGNATURE OF REGISTRAR</p> <p>32. SIGNATURE OF ASSISTANT REGISTRAR</p> <p>33. SIGNATURE OF CLERK</p> <p>34. 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BUREAU V. E.

MAY 7 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04333

4372

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Prince Georges	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cedar Heights		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cedar Heights	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6209-K St.		STREET ADDRESS (If rural, give location) 6209-K St.	
3. NAME OF DECEASED (Type or Print) William Kent		4. DATE OF DEATH (Month) (Day) (Year) April 21 1956	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH June 12 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Const.	9. AGE last birthday 68 yrs.
11. FATHER'S NAME William Kent		12. CITIZEN OF WHAT COUNTRY U.S.	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		14. MOTHER'S MAIDEN NAME Madge Coates	
15. SOCIAL SECURITY No.		17. INFORMANT Mrs. Lucie Kent wife	
16. 577-24-8605			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X Immediate cause (a) Cerebral Hemorrhage
Antecedent cause(s) (b) Hypertension
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

9 mo
?

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION Chronic Nephritis

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from July 27, 1955 to April 21, 1956 that I last saw the deceased alive on April 21, 1956, and that death occurred at 6:10 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
General	4-21-56	Stewart Funeral Home	Washington, DC	DC
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
4-23-56	Carrie F. Campbell	John V. Stewart	3045 14th St. N.W.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4335

CERTIFICATE OF DEATH

043345

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PR Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PR Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVERDALE</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LELAND MEMORIAL HOSP</u>		d. STREET ADDRESS <u>4909 QUEBEC ST</u>	
3. NAME OF DECEASED (Type or print) <u>VINCENT JAMES</u> First Middle Last		4. DATE OF DEATH <u>APR</u> Month Day Year <u>21</u> 19 <u>56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-22-1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired - liquor dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>76</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Kiernan</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hensel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mark J. Kiernan (as above)</u> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, progressive</u> DUE TO <u>Gen. cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gen. cerebral arteriosclerosis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>1-2 Mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) <u></u> (County) <u></u> (State) <u></u>
21. I certify that I attended the deceased from <u>March</u> , 19 <u>56</u> , to <u>April</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-21</u> , 19 <u>56</u> , and that death occurred at <u>3:50</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.L. Etienne</u>		DATE SIGNED <u>4-21-56</u>	
PHYSICIAN'S NAME (Type) <u>W.L. ETIENNE</u>		ADDRESS (Street, city or town, state) <u>4713 Berwyn Rd College Park, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 25, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville Maryland.</u>		24a. REC'D BY REGISTRAR <u>April 23 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. Severe</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

APR 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4373

CERTIFICATE OF DEATH

04335

Reg. Dist. No. 247

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Pr Geo			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham				c. LENGTH OF STAY IN 1b 4 mos			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3 ✓			
d. STREET ADDRESS 1731 Seemann St. N.W.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Harriet Elizabeth King				4. DATE OF DEATH Month Day Year April 11 1956			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH July 29 1865		9. AGE (In years last birthday) 90 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James King				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Miss Eva King		Address Lanham Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Paget D. Jensen							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from Feb. 1956, to April 11, 1956, that I last saw the deceased alive on April 10, 1956, and that death occurred at 3:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Henry A. Wise, Jr.				ADDRESS (Street, city or town, state) 149 9th St, Bowie, Md			
PHYSICIAN'S NAME (Type) Henry A. Wise, Jr.				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-17-56		22c. NAME OF CEMETERY OR CREMATORY Lee Funeral Home Lincoln Mem Cem - S C & Md		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 4899 Lee Funeral Home 389 R I N.V.				24a. REC'D BY REGISTRAR DATE 4/13/56		24b. REGISTRAR'S SIGNATURE Mrs. Carrie Campbell	

BUREAU V. S.

APR 13 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

4374

CERTIFICATE OF DEATH

04338

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince George's County
 City or town Rural Seat Pleasant
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 years
 Hospital, institution, or street address where death occurred:
5980 Addison Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Pr. George's
 City or town Rural Seat Pleasant
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5980 Addison Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war 0

3. (a) FULL NAME

Lottie May King

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband George Wilbert King
 6.(c) If alive, give age 58 years
 7. Birth date of deceased (mo., day, yr.) Oct 9 1888
 8. AGE: Years 67 Months _____ Days _____ It less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH April 9th 19 56 at 2:32 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov 12 19 52 to April 9 19 56
 and that I last saw h. alive on April 9 19 56

Immediate cause of death Cerebral Hemorrhage DURATION 3 days

Due to Malignant Hypertension 4 years

Due to 331X

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. Suit Ritchie M.D.

7005 Ritchie Rd SE M. D. or other

Address Wash 27 D.C. Date signed Apr 9 1956

9. Birthplace Anne Arundel County, Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home
 12. Name Walter Tucker
 13. Birthplace Anne Arundel Co. Md.
 14. Maiden name Mary Margaret Crosby
 15. Birthplace Anne Arundel Co. Md.
 16. Informant Geo. Wilbert King
 Address 5980 Addison Rd SE Wash 27 D.C.
 17. Burial Date thereof April 17 1956
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory FRIENDSHIP M.E. CHURCH CEMETERY
 Location FRIENDSHIP - ANN ARUNDEL CO. MD
 18. Funeral director W.W. CHARPENS CO.
 Address 517-16th ST SE WASH D.C.

Apr 9 19 56 Carrie Campbell
 Date rec'd by registrar Registrar

BUREAU V. S.

APR 12 1956

RECEIVED

4336

CERTIFICATE OF DEATH

04337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Pr. Geo. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>76 Meland Memorial Hosp</u>		d. STREET ADDRESS <u>X</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lizzie</u> Middle <u>Mildred</u> Last <u>Kramer</u>		4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-4-1879</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Middleton</u>		14. MOTHER'S MAIDEN NAME <u>? Va</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>m</u>	
17. INFORMANT <u>Hosp. Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arteriosclerosis</u> DUE TO (c) <u>undetermined</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid arthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 12, 1956</u> , to <u>Apr 22, 1956</u> , that I last saw the deceased alive on <u>Apr 22, 1956</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L.W. Malin MD</u> M.D.		ADDRESS (Street, city or town, state) <u>Riverdale, Md</u> DATE SIGNED <u>4-22-56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE-THEREOF <u>4/25/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lebanon</u>	22d. LOCATION (City, town, or county) (State) <u>Lebanon Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert Funeral Home</u> ADDRESS <u>undated</u>		24a. REC'D BY REGISTRAR <u>APR 26 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Mr. James E. Lewis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH APR 26 1956	
NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		RACE [Faint text]	
PLACE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		MEDICAL HISTORY [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
DATE OF SIGNATURE [Faint text]		DATE OF SIGNATURE [Faint text]	

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APR 26 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 13, Film 195 1-12-56 et

CERTIFICATE OF DEATH

04338

Reg. Dist. No. 232

4375

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Croome		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		d. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) Fannie E. Leake		4. DATE OF DEATH April 4, 1956	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1883
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Rockingham, N. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ?? Leadbetter		14. MOTHER'S MAIDEN NAME Caroline Ledbetter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Annie McClendon		Address Croome, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular renal disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Palmer abscess of the left hand		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2, 1956, to April 4, 1956, that I last saw the deceased alive on April 4, 1956, and that death occurred at 6:45 P. M. from the causes and on the date stated above. DATE SIGNED ACTUAL SIGNATURE James I. Boyd M.D. 8200 Marlboro Pike, S.E. PHYSICIAN'S NAME (Type) James I. Boyd Washington 28, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4-4-56	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE April 7 1956	
24b. REGISTRAR'S SIGNATURE John F. Danner.			

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4376 CERTIFICATE OF DEATH

04340

Reg. Dist. No. 242

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Prince George</u> MARYLAND		STATE <u>47X-3</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Smithland</u>		LENGTH OF STAY (in this place) <u>5 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4500 - Smithland Rd</u>				STREET ADDRESS (If rural give location) <u>1822 - 22nd St. S.E.</u>			
3. NAME OF DECEASED (Type or Print) <u>Philip</u> (First) <u>H.</u> (Middle) <u>Lightfoot</u> (Last)				4. DATE OF DEATH (Month) <u>April</u> (Day) <u>12</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>April 22 - 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Petersburg Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Philip H. Lightfoot</u>				14. MOTHER'S MAIDEN NAME <u>Mannie Claiborne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Philip H. Lightfoot Jr.</u> <u>305 - D - ST. NW - Washington D.C.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
150X IMMEDIATE CAUSE (A) <u>Carcinoma of Esophagus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Comm.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/15/55</u> , 19 , to <u>4/12/56</u> , 19 , that I last saw the deceased alive on <u>4/12/56</u> , 19 , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>William C. Lambert</u> DATE SIGNED <u>4/12/56</u> ADDRESS (Street, city, town, state) <u>M.D. 1418 Ford Hope Rd S.E. Wash. D.C.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-14-56</u>		NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		LOCATION (City, town, or county) (State) <u>Leesburg Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Edna F. Gellum</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Seminario Bros.</u>		ADDRESS <u>1661 - Wood Hope Rd S.E. Wash. D.C.</u>	
DATE <u>4-13-56</u>							

CERTIFICATE OF DEATH

Reg. Dist. No.

2. DEATH PLACE (HOUSE OR HOSPITAL)

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

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INSTRUCTIONS

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CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cottage City,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>				d. STREET ADDRESS <u>4014-Bunker Hill Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Robert Baby</u> First <u>Boy</u> Middle <u>Fingersoll</u> Last <u>Long, Jr.</u>				4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>br</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-20-56</u>	
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>		IF UNDER 24 HRS. Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Long, Robert</u>				14. MOTHER'S MAIDEN NAME <u>Clark, Ann Patricia</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>mother - as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal Atelectasis</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity (32 cm. 600 gms)</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4/20</u> , 19 <u>56</u> , to <u>4/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/22</u> , 19 <u>56</u> , and that death occurred at <u>4:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John W. Perkins</u>				DATE SIGNED <u>4/23/56</u>			
PHYSICIAN'S NAME (Type) <u>John W. Perkins</u>				ADDRESS (Street, city or town, state) <u>5301 Hamilton St. Hyatt, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>May 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges Gen Hosp</u>	
22d. LOCATION (City, town, or county) (State) <u>Chesley, Md</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm W. Ben</u>				ADDRESS <u>Laurel</u>		24a. REC'D BY REGISTRAR DATE <u>5/22/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Annanda Lounney</u>							

MEDICAL CERTIFICATION

1

requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077171250

MAY 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4338 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04341

Reg. Dist. No. 239

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b Transit		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1026 Phillip Powers Drive				d. STREET ADDRESS 834 Sligo Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last Graham Gilmore Ludwig				4. DATE OF DEATH Month Day Year April 3, 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1924		9. AGE (In years last birthday) 31 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Graham Gilmore Ludwig, Sr.				14. MOTHER'S MAIDEN NAME Ethel Hite			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W 11		17. INFORMANT Address Edward A. pierce, 1026 Phillip Powers Drive, Laurel, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia DUE TO Conditions, if any, which gave rise to immediate cause (b) pending (c) pending DUE TO c. pending							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 971.8							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Suicide by consumption of a poisonous solution					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 4-3- 19 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) house		20f. (City or town) (County) (State) Laurel Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John J. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 3, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/6/56		22c. NAME OF CEMETERY OR CREMATORY Thorn Rose Cemetery		22d. LOCATION (City, town, or county) (State) Staunton Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.				24a. REG'D BY REGISTRAR 7-56		24b. REGISTRAR'S SIGNATURE M. P. ...	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ARMY AND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
APR 12 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4377

CERTIFICATE OF DEATH

04342

Reg. Dist. No. 272

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cedar Hgts</u>	
c. LENGTH OF STAY IN 1b <u>25 years</u>		d. STREET ADDRESS <u>1118 65th Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Manns</u> Middle Last		4. DATE OF DEATH <u>April</u> Month <u>2nd</u> Day Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumber Yard</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Stableman, George Mann</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Manns</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>George R. Mann</u> Address <u>6403 - Lee Place</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Dis</u> DUE TO (c) <u>20 years</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Serious</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> to <u>MAY</u> , 1956, that I last saw the deceased alive on <u>Feb 23</u> , 1956, and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John W. Rout</u>		DATE SIGNED <u>3-30-56</u> ST N.E. Wash. D.C.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-7-56</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Southland Rd Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S Washington + Sons</u> ADDRESS <u>467 N 1st St NW</u>		24a. REC'D BY REGISTRAR <u>Apr. 7-56</u> 24b. REGISTRAR'S SIGNATURE <u>Carrie Campbell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES	
JAMES H. HARRIS		Male		45		1880		Baltimore, Md.		Carpenter		Heart Disease		Baltimore, Md.		10:30 AM		J. H. Harris		J. H. Harris		J. H. Harris	
13. MARITAL STATUS		14. EDUCATION		15. RELIGION		16. COLOR		17. ETHNIC ORIGIN		18. SOCIAL CLASS		19. MANNER OF DEATH		20. PLACE OF INTERMENT		21. TIME OF INTERMENT		22. SIGNATURE OF INTERMENT		23. SIGNATURE OF DECEASED		24. SIGNATURE OF WITNESSES	
Married		High School		Roman Catholic		White		Caucasian		Middle Class		Natural		Baltimore, Md.		10:30 AM		J. H. Harris		J. H. Harris		J. H. Harris	
25. DATE OF DEATH		26. TIME OF DEATH		27. PLACE OF DEATH		28. CAUSE OF DEATH		29. PLACE OF DEATH		30. TIME OF DEATH		31. PLACE OF DEATH		32. TIME OF DEATH		33. PLACE OF DEATH		34. TIME OF DEATH		35. PLACE OF DEATH		36. TIME OF DEATH	
April 6, 1956		10:30 AM		Baltimore, Md.		Heart Disease		Baltimore, Md.		10:30 AM		Baltimore, Md.		10:30 AM		Baltimore, Md.		10:30 AM		Baltimore, Md.		10:30 AM	

BUREAU V. 2

APR 6 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04343

4339

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>4hrs. 13min.</u>		d. STREET ADDRESS <u>4805-Queensbury Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Markley</u> Middle <u>—</u> Last <u>Markley</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11, 1956</u>
9. AGE (In years last birthday) <u>4</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>13</u> IF UNDER 24 HRS. Hours <u>4</u> Min. <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Robert E. Markley Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Thelma. Harrison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>mother - as above.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/11/56</u> , 19 <u>56</u> , to <u>4/12/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/12/56</u> , 19 <u>56</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Aaron Dietz</u>		ADDRESS (Street, city or town, state) <u>Hyattsville Md</u>	
PHYSICIAN'S NAME (Type) <u>Aaron Dietz</u>		DATE SIGNED <u>4/13/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges Natl Cemetery</u>		22d. LOCATION (City, town, county) (State) <u>Prince Georges Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel J. Smith</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>5/2/56</u>		DATE <u>—</u>	

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. MARRIAGE	
3. DATE OF DEATH		4. PLACE OF BIRTH	
5. SEX		6. RACE	
7. AGE		8. OCCUPATION	
9. CAUSE OF DEATH		10. MANNER OF DEATH	
11. DATE OF DEATH		12. TIME OF DEATH	
13. PLACE OF DEATH		14. NAME OF DEATH	
15. NAME OF DEATH		16. NAME OF DEATH	
17. NAME OF DEATH		18. NAME OF DEATH	
19. NAME OF DEATH		20. NAME OF DEATH	
21. NAME OF DEATH		22. NAME OF DEATH	
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89. NAME OF DEATH		90. NAME OF DEATH	
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93. NAME OF DEATH		94. NAME OF DEATH	
95. NAME OF DEATH		96. NAME OF DEATH	
97. NAME OF DEATH		98. NAME OF DEATH	
99. NAME OF DEATH		100. NAME OF DEATH	

RECEIVED
JAN 7 1956
BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04344

4340

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colmar Manor,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>3612-39th Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Female Infant</u> First <u>Martin</u> Middle <u>Martin</u> Last <u>Martin</u>		4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-10-56</u>
9. AGE (In years last birthday) yrs. <u>10</u> Min. <u>35</u>		IF UNDER 1 YEAR: Months <u>10</u> Days <u>35</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Martin, Charles</u>		14. MOTHER'S MAIDEN NAME <u>Morgan, Anna Ellen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>mother - as above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (37 cm. 1300 gms.)</u> DUE TO (b) <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u> DUE TO (d) <u></u> DUE TO (e) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/10/1956</u> , to <u>4/10/1956</u> , that I last saw the deceased alive on <u>April 10, 1956</u> , and that death occurred at <u>6:35 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>5301 Hamilton St. Hyattsville, Md.</u> DATE SIGNED <u>4/13/56</u>	
ACTUAL SIGNATURE <u>John W. Perkins</u>		M.D. <u>5301 Hamilton St. Hyattsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John Perkins</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>April 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges Infirmary</u>		22d. LOCATION (City, town, or county) (State) <u>Chesley Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Perkins</u>		ADDRESS <u>5301 Hamilton St. Hyattsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>5/3/56</u>		24b. REGISTRAR'S SIGNATURE <u>Amelia Doumeny</u>	

2077262321

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4341

CERTIFICATE OF DEATH

04345

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Chesley, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 23 Greenbelt	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 77 Prince Georges Jv. Hosp.		d. STREET ADDRESS 1 D Plateau Pk	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Clarke EDWIN Martin		4. DATE OF DEATH Month Day Year April 28, 1956	
5. SEX m	6. COLOR OR RACE w	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 21 1893
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL MINER		10b. KIND OF BUSINESS OR INDUSTRY WEST VIRGINIA SHINNSTON, W. VA.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ELISHA C. MARTIN		14. MOTHER'S MAIDEN NAME ROSA A. BOCK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 232-10-8712	
17. INFORMANT Address CARLOS GOFF 5705-DAVIS BLVD. SE.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery scl. Ht. disease (c) Hemoperitoneum (Post operative)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 20, 1956, to April 28, 1956, that I last saw the deceased alive on April 28, 1956, and that death occurred at 9 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel J. Sugar M.D.		ADDRESS (Street, city or town, state) Mt. Rainier Md. DATE SIGNED 4-28-56	
PHYSICIAN'S NAME (Type) SAMUEL J. SUGAR		MT. RAINIER, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Ship		22b. DATE THEREOF 4/29/56	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) SHINNSTON WEST, VA.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co		ADDRESS Riverdale Md.	
24a. REC'D BY REGISTRAR DATE 4/30/56		24b. REGISTRAR'S SIGNATURE Amanda Downey	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

1951

Reg. Out. No.

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
EDWARD J. MURPHY		M		45		W		1906		BALTIMORE, MD.		MAY 1, 1951		BALTIMORE, MD.		HEART DISEASE		NATURAL		[Signature]		[Signature]	
13. FULL NAME OF MOTHER		14. FULL NAME OF FATHER		15. FULL NAME OF SPOUSE		16. FULL NAME OF CHILD		17. FULL NAME OF GRANDCHILD		18. FULL NAME OF GREAT-GRANDCHILD		19. FULL NAME OF OTHER RELATIVE		20. FULL NAME OF OTHER RELATIVE		21. FULL NAME OF OTHER RELATIVE		22. FULL NAME OF OTHER RELATIVE		23. FULL NAME OF OTHER RELATIVE		24. FULL NAME OF OTHER RELATIVE	
[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	
25. FULL NAME OF OTHER RELATIVE		26. FULL NAME OF OTHER RELATIVE		27. FULL NAME OF OTHER RELATIVE		28. FULL NAME OF OTHER RELATIVE		29. FULL NAME OF OTHER RELATIVE		30. FULL NAME OF OTHER RELATIVE		31. FULL NAME OF OTHER RELATIVE		32. FULL NAME OF OTHER RELATIVE		33. FULL NAME OF OTHER RELATIVE		34. FULL NAME OF OTHER RELATIVE		35. FULL NAME OF OTHER RELATIVE		36. FULL NAME OF OTHER RELATIVE	
[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	
37. FULL NAME OF OTHER RELATIVE		38. FULL NAME OF OTHER RELATIVE		39. FULL NAME OF OTHER RELATIVE		40. FULL NAME OF OTHER RELATIVE		41. FULL NAME OF OTHER RELATIVE		42. FULL NAME OF OTHER RELATIVE		43. FULL NAME OF OTHER RELATIVE		44. FULL NAME OF OTHER RELATIVE		45. FULL NAME OF OTHER RELATIVE		46. FULL NAME OF OTHER RELATIVE		47. FULL NAME OF OTHER RELATIVE		48. FULL NAME OF OTHER RELATIVE	
[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	
49. FULL NAME OF OTHER RELATIVE		50. FULL NAME OF OTHER RELATIVE		51. FULL NAME OF OTHER RELATIVE		52. FULL NAME OF OTHER RELATIVE		53. FULL NAME OF OTHER RELATIVE		54. FULL NAME OF OTHER RELATIVE		55. FULL NAME OF OTHER RELATIVE		56. FULL NAME OF OTHER RELATIVE		57. FULL NAME OF OTHER RELATIVE		58. FULL NAME OF OTHER RELATIVE		59. FULL NAME OF OTHER RELATIVE		60. FULL NAME OF OTHER RELATIVE	
[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	

BUREAU V. 8

MAY 3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04348

231

CERTIFICATE OF DEATH

Reg. Dist. No.

4342

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Cheeverly</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>17 Prince Geo. Gen Hosp</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover Hills</u>	
4. DATE OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Mayberry</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 April 56</u>
9. AGE (In years last birthday) yrs. <u>5 1/2</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William L Mayberry</u>		14. MOTHER'S MAIDEN NAME <u>Cora Blake</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>as above</u>	
17. INFORMANT <u>Mother -</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/13</u> , 19 <u>56</u> , to <u>4/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/13/56</u> , 19 <u>56</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. E. Masser</u> M.D.		ADDRESS (Street, city or town, state) <u>7409 Varnum St</u> DATE SIGNED <u>4/13/56</u>	
PHYSICIAN'S NAME (Type) <u>J. E. Masser</u>		<u>Landover Hills, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prince George Gen Hosp</u>		22d. LOCATION (City, town, or county) (State) <u>Cheeverly Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Penn</u> ADDRESS <u>P. Synt</u>		24a. REC'D BY REGISTRAR DATE <u>5/2/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mauda Dourney</u>			

2077354322

BUREAU V. S.

MAY 7 1956

RECEIVED

4343

MEDICAL CERTIFICATION

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

04348

4378

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH- COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE D. C. COUNTY -	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glenn Dale (rural)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington 47X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital		STREET ADDRESS 2603 3rd St., N. E.	
3. NAME OF DECEASED (Type or Print) THOMAS (First) M (Middle) McVEY (Last)		4. DATE OF DEATH (Month) 4 (Day) 7 (Year) 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 6/4/1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trainman		10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad	9. AGE last birthday 71 yrs.
13. FATHER'S NAME George W. McVey		14. MOTHER'S MAIDEN NAME Martha Rogers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. 705-07-4214	
17. INFORMANT AND ADDRESS Decedent		12. CITIZEN OF WHAT COUNTRY? USA	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH 6 weeks
18. MEDICAL CERTIFICATION		
(a) Immediate cause Cor Pulmonale		6 weeks
(b) Antecedent cause(s) Idiopathic Bilateral Pulmonary Fibrosis		
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 2/8, 1956, to 4/7, 1956, that I last saw the deceased alive on 4/7, 1956, and that death occurred at 11:45P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL OR CREMATION
(Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG. 4/8/56

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

BUREAU V. S.

APR 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4310
CERTIFICATE OF DEATH04349
Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville				c. LENGTH OF STAY IN 1b 14 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Convalescent Home				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 15			
d. STREET ADDRESS 3606 - Longfellow street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last John W. Middleton				4. DATE OF DEATH Month 4 - Day 20 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/29/1871	
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Div. Mgr. American Oil Company				10b. KIND OF BUSINESS OR INDUSTRY Bowie, Maryland			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Middleton				14. MOTHER'S MAIDEN NAME Virginia Webb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 229-09-4416			
17. INFORMANT Mrs. Olga Winte				3606 - Longfellow street Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 151X <i>Isch - intestinal hemorrhage</i> DUE TO (b) <i>Carcinoma of Stomach</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral vascular disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>years</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Dec.</i> , 19 <i>55</i> , to <i>Apr.</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Apr.</i> , 19 <i>56</i> , and that death occurred at <i>10 P. M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Arnold A. Lear</i> M.D.				ADDRESS (Street, city or town, state) <i>4314 Gallatin St. Hyattsville Md</i>			
PHYSICIAN'S NAME (Type) <i>ARNOLD A. LEAR</i>				DATE SIGNED <i>4-21-56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>4/23/56</i>			
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>				22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nalley Funeral Home</i> ADDRESS <i>3200 R.I. Ave. Mt. Rainier, Md.</i>							
24a. REC'D BY REGISTRAR <i>April 22 1956</i>				24b. REGISTRAR'S SIGNATURE <i>Mrs. Jas. Severe</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 23 1956

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4344

Item 2, See: Birth Cert.

CERTIFICATE OF DEATH

04350

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pri. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kentland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>7627 Goodland Dr.</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Gail</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1956</u>
9. AGE (In years last birthday) <u>762.5</u>		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>16</u> Hours <u>19</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Miller, Herbert</u>		14. MOTHER'S MAIDEN NAME <u>Ferrin, Jean</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>mother - as above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory asphyxia</u> DUE TO <u>prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>prematurity</u> DUE TO (c) <u>prematurity</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/1/56</u> , 19 <u>56</u> to <u>4/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/16</u> , 19 <u>56</u> , and that death occurred at <u>2</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Hageage</u>		ADDRESS (Street, city or town, state) <u>Cottage City, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George Hageage</u>		DATE SIGNED <u>4/1/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prince Georges Burial</u>		22d. LOCATION (City, town, or county) (State) <u>Cheverly Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Danny W. Penn</u>		ADDRESS <u>Rayet</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Amanda Dourney</u>	
DATE <u>3/2/56</u>			

2077275270

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04351231
Reg. Dist. No.

4345

1. PLACE OF DEATH a. COUNTY <u>Prince Georges'</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE . b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 <u>Chesapeake</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 77 <u>Prince Georges' General Hospital</u>		d. STREET ADDRESS <u>3014 S. Dakota</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary E. Miller</u>		4. DATE OF DEATH Month Day Year <u>4 / 2 19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-1891</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Union</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Westnedge</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Bergmann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>577-09-9456</u>	
17. INFORMANT <u>Statistie Card</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, Pancreas</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-30-55</u> , 19 <u>55</u> to <u>4/2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/2</u> , 19 <u>56</u> , and that death occurred at <u>7:15</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald W. Mitchell</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>1746 1st N.W. Wash DC 2-56</u>	
PHYSICIAN'S NAME (Type) <u>Donald W. Mitchell</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-4-56</u>	
22c. NAME OF CEMETERY OF CREMATORY <u>PROSPECT Hill CEMETARY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co</u>		ADDRESS <u>2901 14th St N.W. D.C.</u>	
24a. REC'D BY REGISTRAR <u>4/3/56</u>		24b. REGISTRAR'S SIGNATURE <u>Amanda Downey</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED James Thompson		2. SEX Male		3. AGE 62	
4. RACE White		5. DATE OF BIRTH 1911-12-25		6. PLACE OF BIRTH Western Union	
7. OCCUPATION Retired		8. MARITAL STATUS Married		9. DATE OF DEATH 1956-04-05	
10. PLACE OF DEATH Home		11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural	
13. SIGNATURE OF PHYSICIAN [Signature]		14. SIGNATURE OF DECEASED [Signature]		15. SIGNATURE OF WITNESSES [Signature]	
16. SIGNATURE OF REGISTRAR [Signature]		17. SIGNATURE OF CLERK [Signature]		18. SIGNATURE OF JURY [Signature]	

BUREAU V. S.

APR 5 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

243

4379

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Bowie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1013 Brady Ave.		d. STREET ADDRESS 1013 Brady Ave.	
3. NAME OF DECEASED (Type or print) Margaret Morgan		4. DATE OF DEATH April 3 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec-1879 78
9. AGE (in years last birthday) 78		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Wm. K. White		14. MOTHER'S MAIDEN NAME Ida. R. Polley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Anna S. Wildman		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac failure DUE TO (c) Essential Hypertension INTERVAL BETWEEN ONSET AND DEATH 24 hrs 3 yrs 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1955, to 4-3 1956, that I last saw the deceased alive on 4-3 1956, and that death occurred at 9:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4-4-56			
ACTUAL SIGNATURE Frank J. Weary M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		4-6-56	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Cedar Hill Cemetery		Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
F. Brach Jones		Hyattsville Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE 4-7-56		Agnes M. Givling	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

4573

Form with multiple sections for death certificate, including fields for name, date, and cause of death. The text is mostly illegible due to blurriness.

BUREAU V. S.

APR 10 1956

RECEIVED



THE LIBRARY OF THE
MARYLAND STATE DEPARTMENT OF HEALTH
BALTIMORE, MARYLAND

4346

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>1801- Clyde Road NW</u>			
3. NAME OF DECEASED (Type or print) <u>John Joseph Murphy</u>				4. DATE OF DEATH <u>April 14 1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 2, 1921</u>	
9. AGE (In years last birthday) <u>34</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Healing</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. &</u>	
13. FATHER'S NAME <u>John Joseph Murphy</u>				14. MOTHER'S MAIDEN NAME <u>Helen Hicks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes & unknown</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>John D Wallop</u> Address <u>3435 S 48 Street Arlington Va</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO <u>Crushed Chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Run over by auto on freeway that turned over</u>					
20c. TIME OF INJURY <u>3:30 p.m. April 14 1956</u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not while at work</u> <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Interpreway</u>		20f. (City or town) <u>Upper Marlboro P.D.</u> (County) <u>Prince Georges</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 15, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cem.</u>		22d. LOCATION (City, town, or county) <u>Arlington, Virginia</u> (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. News Co.</u> ADDRESS <u>2901 14th St., N.W. Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR <u>4/18/56</u>		24b. REGISTRAR'S SIGNATURE <u>Manda Dourney</u>	

MEDICAL CERTIFICATION

38

99

M

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16

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CLERGY		18. SIGNATURE OF OTHER	
19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

BUREAU V. S.

APR 20 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 and 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4380 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04354
Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>5 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carole Highlands, West Hyattsville</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7401- 18th Avenue</u>				d. STREET ADDRESS <u>7401 18th Avenue</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Lawrence</u> Middle <u>Marshall</u> Last <u>Niles</u>				4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>19 56</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 4, 1954</u>			
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Richard Niles</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Jane Shrout</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>James R. Niles, 7401 18th Avenue</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Bronchopneumonia</u> (c) <u> </u> DUE TO (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>John T. Maloney</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>April 1, 1956</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/4/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NAT'L. MEM. PARK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH, VIRGINIA</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>April 3 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Jas. B. Beyer</u> Deputy			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, date, time, place, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

APR 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4347

CERTIFICATE OF DEATH

04355

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Rainier	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges San Asylum		e. STREET ADDRESS 3119 Queens Chapel Rd	
3. NAME OF DECEASED (Type or print) First Middle Last Julia Nyborg		4. DATE OF DEATH Month Day Year 4-30-56	
5. SEX F	6. COLOR OF RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-4-72
9. AGE (In years last birthday) 83		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Norway		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Dehydration (b) generalized arteriosclerosis (c) DUE TO CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 month 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 30, 1956 to Apr 20, 1956 that I last saw the deceased alive on Apr 20, 1956, and that death occurred at 10:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel J. N. Sugar M.D.		ADDRESS (Street, city or town, state) Mt Rainier, Md DATE SIGNED Apr 21, 1956	
PHYSICIAN'S NAME (Type) Samuel J. N. Sugar			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 4/22/56	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Madison, Wis	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home Inc. By Wm. L. Nalley		24a. REC'D BY REGISTRAR DATE 4/23/56	
ADDRESS Mt Rainier, Md		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

APR 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04356

Reg. Dist. No.

231

4381

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover</u>			c. LENGTH OF STAY IN 1b <u>8 mos</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Marine Home for Retarded Children</u>			d. STREET ADDRESS <u>3609 - Copley Road</u>		
3. NAME OF DECEASED (Type or print) First <u>STEVEN</u> Middle <u>JOEL</u> Last <u>OFFIT</u>			4. DATE OF DEATH Month <u>4</u> - Day <u>3</u> - Year <u>1956</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>3-24-55</u>		9. AGE (In years lost birthday) yrs. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.G.</u>
13. FATHER'S NAME <u>Sylvan Offit</u>			14. MOTHER'S MAIDEN NAME <u>Eileen Bernstein</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Records of Marine Home</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exhaustion</u> <u>325.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malnutrition</u> DUE TO (c) <u>Mongolism</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>55</u> , to <u>Apr 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Apr 1</u> , 19 <u>56</u> , and that death occurred at <u>7:00 P.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>John J. Maloney</u>		ADDRESS (Street, city or town, state) <u>Chesley, Md</u>		DATE SIGNED <u>4-3-56</u>	
PHYSICIAN'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Apr 4 56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Muckio Rodesh</u>	22d. LOCATION (City, town, or county)	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Lewinson & Bur</u>		ADDRESS <u>1124-26 W. North Ave</u>		24a. REC'D BY REGISTRAR <u>APR 4 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Amanda Downey</u>

BUREAU V. S.

APR 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4348 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04357

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>28</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>773307-Bellerue Ave.</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr-Geo</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> d. STREET ADDRESS <u>3307 Bellerue Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>John Nicholas Ogle</u>				4. DATE OF DEATH Month <u>7</u> - Day <u>28</u> - Year <u>1956</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 5, 1888</u>		9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.G.</u>	
13. FATHER'S NAME <u>John Henry Ogle</u>				14. MOTHER'S MAIDEN NAME <u>Christiana Madary</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>WW #1</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Louise M. Ogle</u> Address <u>Cheverly Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443x Acute congestive heart failure</u> DUE TO (b) <u>Hypertensive cerebrovascular disease</u> DUE TO (c) <u>Essential hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		Month, Day, Year <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <u>John J. Maloney</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 28, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Interment</u>		22b. DATE THEREOF <u>May 1, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Calverton, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee & Co.</u>				ADDRESS <u>3004 S.W. 5</u>		24a. REC'D BY REGISTRAR <u>DATE 5/1/56</u>		24b. REGISTRAR'S SIGNATURE <u>Wanda Lounney</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the executor of the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 could be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
1973 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. Includes checkboxes for various conditions and a large area for handwritten notes.

BUREAU V. 3

MAY 3 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the case file should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4349 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04358

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 79 Leland Memorial Hospital			d. STREET ADDRESS 10606 Baltimore Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Janapher Rebecca Pettys			4. DATE OF DEATH Month Day Year April 10 1956		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1886	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 69
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Simeon F. Denty			14. MOTHER'S MAIDEN NAME Janapher R. Rotchford		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Joseph Nichols, Cottage City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Exhaustion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Iron deficiency anemia.					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE John T. Maloney			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) John T. Maloney, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 10, 1956		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-12-56		22c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR April 14, 1956	
				24b. REGISTRAR'S SIGNATURE Mrs. Jas. Sever	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. The text is mostly illegible due to the quality of the scan.

BUREAU V. S.

APR 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4382

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04359
Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills		c. LENGTH OF STAY IN 1b 6 1/2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4112 Fairfax Street				d. STREET ADDRESS 4112 Fairfax Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle Picard Last Picard				4. DATE OF DEATH Month April Day 9 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1872		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 84 Days 84	IF UNDER 24 HRS. Hours 84 Min. 84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wyoming		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roscoe Facer				14. MOTHER'S MAIDEN NAME Lavenia Hammond			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Hyattsville, Md. James R. Face, 3602 Longfellow St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential hypertension							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John J. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-12-56		22c. NAME OF CEMETERY OR CREMATORY FT LINCOLN	
				22d. LOCATION (City, town, or county) (State) BLADENSBURG Md			
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home				ADDRESS 4812 Lee Ave NW		24a. REC'D BY REGISTRAR DATE 4/13/56	
				24b. REGISTRAR'S SIGNATURE Mrs. Amanda Shoney			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" should be written in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is mostly blank with some faint markings.

John D. McHenry

BUREAU V. 3.

APR 13, 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the funeral director. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4350 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04360

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly Md.		c. LENGTH OF STAY IN 1b D O A		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier Md. 16					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 99 Prince Georges General Hospital				d. STREET ADDRESS 3260 Queenstown Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Franklin Powers				4. DATE OF DEATH Month Day Year April 7, 19 56.					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 1, 1899			
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Washington Terminal		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Frank Powers				14. MOTHER'S MAIDEN NAME Eliza Easton					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 718-14-9719		17. INFORMANT Mabel Powers					
				1114 F Street N E. Washington D. C.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 540.1 Zosteremia DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute generalized peritonitis (c) Ruptured peptic ulcer DUE TO cause lost.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE John J. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) JOHN T. MALONEY, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 8 - 1956					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/10/56		22c. NAME OF CEMETERY OR CREMATORY virts		22d. LOCATION (City, town, or county) (State) Sandy hook, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Fute Brunswick, Maryland				24a. REC'D BY REGISTRAR DATE APR 10 1956		24b. REGISTRAR'S SIGNATURE Amanda Downey			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
1917 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 10 1956

RECEIVED

4311

CERTIFICATE OF DEATH

04362

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PR Geo MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY PR Geo	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		c. LENGTH OF STAY IN 1b 2 wks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4318 - TUCKERMAN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLLEGE PARK	
		d. STREET ADDRESS BRANCHVILLE RD	
3. NAME OF DECEASED (Type or print) FRANK AMOS RATCLIFF		4. DATE OF DEATH APR 20 1956	
5. SEX M	6. COLOR OR RACE CU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-27-1882
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Armco steel Corporation	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Ratcliff		14. MOTHER'S MAIDEN NAME Huldah Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT Mrs. Addie Marsh University Park, Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC Congestive Heart Failure 450.0 DUE TO auricular FIBRILLATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. GENERALIZED ARTERIO SCLEROSIS DUE TO GENERALIZED ARTERIO SCLEROSIS DUE TO GENERALIZED ARTERIO SCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY TUBERCULOSIS & cavitation - active		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH , 19 56 , to APRIL , 19 56 , that I last saw the deceased alive on 4-16 , 19 56 , and that death occurred at 3:30 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE W.L. Etienne		DATE SIGNED 4-19-56	
PHYSICIAN'S NAME (Type) W.L. ETIENNE		COLLEGE PARK, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation		22b. DATE THEREOF 4/22/56	
22c. NAME OF CEMETERY OR CREMATORY Ironton		22d. LOCATION (City, town, or county) (State) Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		ADDRESS	
24a. REC'D BY REGISTRAR April 21 1956		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. PLACE OF BIRTH Maryland	
5. DATE OF DEATH April 23, 1956		6. TIME OF DEATH 10:00 AM		7. PLACE OF DEATH Home		8. CAUSE OF DEATH Heart Disease	
9. DISEASE OR INJURY Coronary Artery Disease		10. PERIOD OF ILLNESS Several weeks		11. PRESENTING COMPLAINTS Chest pain, shortness of breath		12. TREATMENT Medical	
13. SIGNATURE OF PHYSICIAN J. H. Harris		14. SIGNATURE OF WITNESSES J. H. Harris		15. SIGNATURE OF DECEASED J. H. Harris		16. SIGNATURE OF FUNERAL HOME J. H. Harris	
17. SIGNATURE OF REGISTRAR J. H. Harris		18. SIGNATURE OF CLERK J. H. Harris		19. SIGNATURE OF CHIEF OF BUREAU J. H. Harris		20. SIGNATURE OF DIRECTOR J. H. Harris	

BUREAU V. S.

APR 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

04363

4383

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH- COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE D. C. COUNTY -	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glenn Dale (rural)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital		STREET ADDRESS (If rural, give location) 818 N. Capitol St., N. W.	
3. NAME OF DECEASED (First) (Middle) (Last) CLYDE N. ROCKETT		4. DATE (Month) (Day) (Year) OF DEATH April 29 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Separated, not legally	8. DATE OF BIRTH 8/9/1912
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY N. Cap. Market	9. AGE last birthday 43 yrs.
11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oscar Rockett		14. MOTHER'S MAIDEN NAME Lovancy Bernard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) No		16. SOCIAL SECURITY No. 237-03-5285	
17. INFORMANT AND ADDRESS Decedent			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
162X Immediate cause (a) Bronchogenic Carcinoma, Right Lung			2 weeks
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
11. OTHER SIGNIFICANT CONDITIONS (c) Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary Tuberculosis			Unknown
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/29, 1956, to 4/29, 1956, that I last saw the deceased alive on 4/28, 1956, and that death occurred at 12:50 AM, from the causes and on the date stated above.			
SIGNATURE David S. P. Finerman		ADDRESS Glenn Dale Hospital Glenn Dale, Md.	DATE SIGNED 4/29/56
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 5-2-56	NAME OF CEMETERY OR CREMATORY Wash. Nat'l cemetery	LOCATION (City, town, or county) (State) Suitland, Md.
DATE REC'D BY LOCAL REG. 4/29/56	REGISTRAR'S SIGNATURE L. Weiss	24. FUNERAL DIRECTOR W. W. Chambers Co. Ruxdale Md. for M. Spalding	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 3 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

04364

2411 N. Charles Street, Baltimore

4384

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH COUNTY Pr. Geo's MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Pr. Geo's	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Mitchellville		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Mitchellville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS -		STREET ADDRESS - (If rural, give location)	
3. NAME OF DECEASED (Type or Print) Rose (First) Marie (Middle) Rodenhauer (Last)		4. DATE OF DEATH April 13 1956	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH July 13, 1908
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSW		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE last birthday 47 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES CATTIGO		14. MOTHER'S MAIDEN NAME CARMEIA DEBARONES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		17. INFORMANT Mrs. Doris Garrick Mitchellville, Md.	
16. SOCIAL SECURITY No.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
157X Immediate cause (a) Carcinomatosis		2 months
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cancer Pancreas		7 months
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Feb., 1956, to 4/13, 1956, that I last saw the deceased alive on 4/7, 1956, and that death occurred at 1:00 p.m., from the causes and on the date stated above.		
SIGNATURE H. James Kurtz M.D.		DATE SIGNED 4/13/56
23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 4/17/56		NAME OF CEMETERY OR CREMATORY Mt. Oak Cemetery
LOCATION (City, town, or county) Mitchellville		(State) Md.
DATE REC'D BY LOCAL REG. 4-19-56		24. FUNERAL DIRECTOR ADDRESS Ritchie Bros. Upper Marlboro, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 24 1956

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 could be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										04365		
4351 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 231		
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Geo.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly					c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg 33					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 99 Prince Georges General Hosp.					d. STREET ADDRESS 5303 Tilden Rd.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last George S. Rush					4. DATE OF DEATH		Month 4		Day 7		Year 19 56	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 30, 1896		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Refrigeration Mech.				10b. KIND OF BUSINESS OR INDUSTRY Refrigeration		11. BIRTHPLACE (State or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edward Rush					14. MOTHER'S MAIDEN NAME Veronica Ulrice							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 577-05-6730		17. INFORMANT Mary Rush - Same as #2.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.9 Cachexia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 20fermia DUE TO (c) Generalized carcinomatosis (primary site unk.)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 4/10/56		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln			22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE John T. Maloney					ADDRESS 3200 R.I. Ave. Mt. Rainier, Md.		24a. REC'D BY REGISTRAR DATE 4/10/56		24b. REGISTRAR'S SIGNATURE Amanda Dourney			

MEDICAL CERTIFICATION

2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 11 1956

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04366

Item 9, Film G 195, 4/10/56

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Nursing Home				d. STREET ADDRESS 5106 Crittenden St			
3. NAME OF DECEASED (Type or print) First James Middle Franklin Last Rushe				4. DATE OF DEATH Month April Day 1, Year 19 56			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 17, 1874	
9. AGE (In years last birthday) 82 1/2 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction plumber		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Noble F. Rushe				14. MOTHER'S MAIDEN NAME Lilly Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Frances Mc Namee Laurel Maryland R. F. D. #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.2 hypercardial disease of the heart DUE TO (b) Brondofuerevici DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-4, 1940, to 4-1, 1956 that I last saw the deceased alive on 3-31, 1956, and that death occurred at M, from the causes and on the date stated above.							
ACTUAL SIGNATURE A Deitz		ADDRESS (Street, city or town, state) M.D. 4314 Spalden St Hyattsville Md DATE SIGNED 4-3-56					
PHYSICIAN'S NAME (Type) A Deitz							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 4, 1956		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR DATE April 4, 1956		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Serrero Deputy	

RECEIVED

4385

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04367

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Pr. George</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Pr Geo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Selesia (Rural)</u> LENGTH OF STAY (In this place) <u>40 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Selesia (Rural)</u> <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9390 Old Fort Rd S.E.</u>		STREET ADDRESS (If rural, give location) <u>9392 Old Fort Rd S.E.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Rosie Shorter</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 12 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>(WIDOWED)</u>	8. DATE OF BIRTH <u>Feb. 2 (?)</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday (If under 1 year Months Days Hours Min.) <u>85 (?) yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>St. Mary's County, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Abraham Ford</u>		14. MOTHER'S MAIDEN NAME <u>Sylvia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Jennie Ford</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

351X

Immediate cause

(a) Myocardial De compensation

INTERVAL BETWEEN ONSET AND DEATH

10 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Multiple Decubitus Ulcers3 months(c) Right Hemiplegia & Spastic Paraplegia7 yr.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒ (STATE)

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1/23/56, 19....., to 4/12, 1956, that I last saw the deceased alive on 4/11/56, 19....., and that death occurred at 1.00 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4-14/56</u>	NAME OF CEMETERY OR CREMATORY <u>Grace Church Cemetery</u>	LOCATION (City, town, or county) (State) <u>Chapel Hill Md.</u>
DATE RECD BY LOCAL REG. <u>4/17/56</u>	REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>	24. FUNERAL DIRECTOR <u>Hunt Funeral Home</u>	ADDRESS <u>Waldorf Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 18 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4352

CERTIFICATE OF DEATH

04368

239

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Prince George</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Laurel</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Laurel Sanitarium</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> TOWN <u>15562</u> STREET ADDRESS <u>3705 Fairly Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Ella C</u> (First) (Middle) (Last) <u>Simcox</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 9 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Dec. 7, 1880</u>
9. AGE last birthday <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Govt. clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Harrisonburg Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Scott Cordell</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Mc Galis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>77-17-10000</u>	
17. INFORMANT & ADDRESS <u>Miss Virginia S. S. (daughter)</u> <u>3705 Fairly St. Silver Spring, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>General Arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cerebral Hemorrhages - 3 attacks 1940</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u> <u>since</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Second) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5-22</u> , 19 <u>52</u> , to <u>4-9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-9</u> , 19 <u>56</u> , and that death occurred at <u>12:20 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>Jesse C. Crogers</u> M.D.		ADDRESS (Street, city, town, State) <u>Laurel Sanitarium Laurel Md</u>	
DATE SIGNED <u>4/9/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/12/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		LOCATION (City, town, or county) <u>Prince Georges Co., Md</u>	
24. RECD BY REGISTRAR <u>Apr 10 - 56</u>		REGISTRAR'S SIGNATURE <u>M. Bushman</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph S. Sanderis</u>		ADDRESS <u>1756 Penna Ave NW</u> <u>Washington, DC</u>	

CERTIFICATE OF DEATH

Form D-1-10

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
SEX		AGE		OCCUPATION	
MARRIAGE		EDUCATION		RELIGION	
BIRTH		DEATH		CAUSE OF DEATH	
FATHER		MOTHER		DIAGNOSIS	
SIBLINGS		PREVIOUS ILLNESS		TREATMENT	
BLOOD RELATIONSHIP		MANNER OF DEATH		CERTIFICATE NO.	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICER OF THE DISTRICT IN WHICH THE DECEASED RESIDES.

RECEIVED

RECEIVED
APR 12 1950
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4353

CERTIFICATE OF DEATH

04370

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine, md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>V.</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-78</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>John W. Smith</u> Address <u>Rt. 2, Box 322, Brandywine, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>4/6X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombosis of left pulmonary artery</u> DUE TO <u>2 weeks</u> (c) <u>Chronic Adhesive Pericarditis</u> <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis with gangrene of the right leg</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-16</u> , 19 <u>56</u> , to <u>4-10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-10</u> , 19 <u>56</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel J. N. Sugar</u> M.D.		ADDRESS (Street, city or town, state) <u>Mt. Carmel Md</u> DATE SIGNED <u>4/10/56</u>	
PHYSICIAN'S NAME (Type) <u>Samuel J. N. Sugar, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/13/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros.</u> ADDRESS <u>Upper Marlboro, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>4/12/56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Annanda Downey</u>	

CERTIFICATE OF DEATH

1953

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

APR 16 1956

RECEIVED

4354

CERTIFICATE OF DEATH

04371

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>24 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hospital</u>				d. STREET ADDRESS <u>5214 Paducah St.</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Martin</u> Last <u>Springer</u>				4. DATE OF DEATH Month <u>4</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 24, 1890</u>	
9. AGE (In years last birthday) <u>76 yrs.</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>19</u> Min. <u>56</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>10</u> Hours <u>19</u> Min. <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumberman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NUMBER LOGGING</u>			
11. BIRTHPLACE (State or foreign country) <u>New York</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Unknown Springer</u>				14. MOTHER'S MAIDEN NAME <u>CECELIA Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Hospital Record</u> Address <u>637 N ST. N.W. Wash. D.C.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cor Congestive Heart Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> 450.0 DUE TO (b) <u>Generalized arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Chr. Atrial Fibrillation</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Not Accidental</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4-9</u> , 19 <u>56</u> , to <u>4-10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-9</u> , 19 <u>56</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. L. Etienne</u> M.D.				ADDRESS (Street, city or town, state) <u>4713 - Kensington St. Md.</u> DATE SIGNED <u>4/10/56</u>			
PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u>				College Park, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>APRIL 12, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASH. LEN</u>		22d. LOCATION (City, town, or county) (State) <u>RIGGS RD. RIGGS CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Dally</u> ADDRESS <u>254 CARROLL ST. NW</u>				24a. REC'D BY REGISTRAR <u>April 11 1956 Mrs. Jan. Senechal</u>			
24b. REGISTRAR'S SIGNATURE <u>Refutes</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 12 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4355 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **0432245**

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland Prince Georges COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md.			25	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial				d. STREET ADDRESS 5615 Patterson St			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle James Last Strickland				4. DATE OF DEATH Month April Day 7, Year 19 56.				
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 3, 1917		9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oil Burner Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Stewart Co.		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Rudolph Strickland				14. MOTHER'S MAIDEN NAME Laura Smith				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. W W 11		17. INFORMANT Michael Paulino		Address Lanham, Maryland.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage & shock DUE TO 819X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laceration of abdominal aorta DUE TO Fracture dislocation of 12th thoracic & 1st lumbar vertebrae (c) Fracture dislocation of 12th thoracic & 1st lumbar vertebrae							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drove his automobile into a telegraph pole					
20c. TIME OF INJURY Month, Day, Year Hour 5:29 p. m. 4/7/ 19 56		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) (County) (State) Berwyn Pro Geo Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) John T. Maloney M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED April 8, 1956				
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/10/56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR April 9-56 James Avery		
24b. REGISTRAR'S SIGNATURE								

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the medical examiner, or by a physician, and should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
1955 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 11 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 18 Film G198 5-28-56 ams

Reg. Dist. No.

245

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville	
c. LENGTH OF STAY IN 1b 7 months		d. STREET ADDRESS 2615 Nicholson St. Apt. 201	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2615 Nicholson Street Apt. 201		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOYCE Middle ILENE Last THOMAS		4. DATE OF DEATH Month April Day 29th Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10th, 1936
9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months 19 Days 19	IF UNDER 24 HRS. Hours 19 Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receptionist		10b. KIND OF BUSINESS OR INDUSTRY Doctor's Office	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur K. Hamlett		14. MOTHER'S MAIDEN NAME Marjorie Huff	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Peggy Jean Mason		Address 2615 Nicholson St. West Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Unknown DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 29th, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/30/1956	22c. NAME OF CEMETERY OR CREMATORY Purdum Cemetery	22d. LOCATION (City, town, or county) (State) Keosauqua, Iowa.
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR May 1, 1956	
		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

MAY 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04374

4356 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u> c. LENGTH OF STAY IN 1b <u>11 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>76 Leland Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u> d. STREET ADDRESS <u>4805 Nicholson</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Brian Scott Thompson</u>				4. DATE OF DEATH Month Day Year <u>April 17, 1956</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 10, 1948</u>		9. AGE (In years last birthday) <u>7</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.: Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Earl J. Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Irma Emma Witten</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mother, Same address</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>812X Hemorrhage and shock</u> DUE TO (b) <u>Fracture of skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)								INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ran in front of and was struck by an automobile.</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u>2:40</u> P. M. <u>4-16-1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Riverdale</u> (County) <u>Pr. Geo.</u> (State) <u>Md.</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John T. Maloney</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>April 17, 1956</u>			
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				22a. REC'D BY REGISTRAR <u>Ms. Jas. Severe</u> 24b. REGISTRAR'S SIGNATURE <u>Deputy</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/19/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) <u>Arlington</u> (State) <u>Va.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville Md.</u>		24a. REC'D BY REGISTRAR <u>Ms. Jas. Severe</u> 24b. REGISTRAR'S SIGNATURE <u>Deputy</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1158 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

APR 23 1956

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

04375

4386

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH- COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>D. C.</u> COUNTY <u>-</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glenn Dale (rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glenn Dale Hospital</u>		STREET ADDRESS (If rural, give location) <u>2219 10th St., N. W.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>JAMES</u> (Middle) <u>-</u> (Last) <u>THOMPSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April</u> <u>3</u> <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5/26/1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pepco</u>	9. AGE last birthday <u>51</u> yrs. If under 1 year: Months <u>-</u> Days <u>-</u> If under 24 hrs: Hours <u>-</u> Mins <u>-</u>
11. BIRTHPLACE (State or foreign country) <u>Mullins, S. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Sally Blackman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Decedent</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cor pulmonale with Congestive Heart Failure</u>			<u>1 day</u>
Antecedent cause(s) (b) <u>Pulmonary Tuberculosis</u>			<u>6 mo.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arterio Sclerosis</u>			<u>Unknown</u>
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4/2/56</u> , 19....., to <u>4/3/56</u> , 19....., that I last saw the deceased alive on <u>4/3/56</u> , 19....., and that death occurred at <u>6:50 p.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Francis D. Coste M.D.</u>		ADDRESS <u>Glenn Dale, Md.</u>	
DATE SIGNED <u>4/4/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	DATE <u>4/4/56</u>	NAME OF CEMETERY OR CREMATORY <u>Washington</u>	LOCATION (City, town, or county) (State) <u>D.C.</u>
DATE REC'D BY LOCAL REG. <u>4/3/56</u>	REGISTRAR'S SIGNATURE <u>W. W. Wess</u>	24. FUNERAL DIRECTOR <u>Francis Daniel Home Inc.</u>	
		ADDRESS <u>389 R. I. N. Y.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 10 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, including the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 1, 2, and 3 should be forwarded to the State Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										04376	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 231	
1. PLACE OF DEATH a. COUNTY Princes Georges MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Pr. Georges						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxen Hill Run			c. LENGTH OF STAY IN lb 4 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxen Hill Run					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2206 Chadwick St.					d. STREET ADDRESS 2206 Chadwick St.						
3. NAME OF DECEASED (Type or print) First John Middle Henry Last Tippett					4. DATE OF DEATH Month April Day 23 Year 19 56						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 29, 1888		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mechanic			10b. KIND OF BUSINESS OR INDUSTRY Wash. Gas Co.			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas W. Tippett					14. MOTHER'S MAIDEN NAME Annie Stanton						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) WW-1					16. SOCIAL SECURITY NO. 577-07-7708		17. INFORMANT Melvin L. Tippett 2204 16th, St. S.E. Washington, D.C.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema & congestion, Cerebral edema 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute congestive heart failure (a), stating the underlying cause lost. DUE TO Poisoning by Ethyl alcohol (acute) (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE John J. Maloney					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> April 23, 1956						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 4-26-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l.			22d. LOCATION (City, town, or county) (State) Arlington, Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Signatures Bros.					ADDRESS 1661 Good Hope Rd., S.E. Washington DC			24a. REC'D BY REGISTRAR 4/23/56		24b. REGISTRAR'S SIGNATURE Manda Drusey	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDIC 1 EXAMINER'S CERTIFICATE OF DEATH

(over-indulgence)

RECEIVED
APR 26 1956
BUREAU V. S.

4388

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04377

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kenilworth</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47x3			
c. LENGTH OF STAY IN 1b <u>transit</u>				d. STREET ADDRESS <u>2918 - 26th, St. N.E.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pensylvania Railroad Tracks</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elton</u> Middle <u>Cohen</u> Last <u>Toland</u>				4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 10, 1947</u>	
9. AGE (In years last birthday) <u>8</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>18</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Elton Cohen Toland Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn Alexander</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Evelyn Toland - Same as #2.</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO (b) <u>Multiple fractures, lacerations and amputations.</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by Pensylvania Railroad passenger train.</u>			
20c. TIME OF INJURY Month, Day, Year <u>4-18 19 56</u> Hour <u>7:15</u> p. m.		20d. INJURY OCCURRED <u>White</u> at work <input type="checkbox"/> <u>Not white</u> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>R.R. Tracks</u>		20f. (City or town) <u>Kenilworth, Pr. Geo. Md.</u> (County) <u></u> (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 18, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u></u>		22b. DATE THEREOF <u>4/18/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) <u>Washington D.C.</u> (State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.H. Brown Co 1322 Univ St NW</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR <u></u> DATE <u>25 1956</u>		24b. REGISTRAR'S SIGNATURE <u>A.W. Hedrick</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use execution of the certificate, pending the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 25 1936

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4389

CERTIFICATE OF DEATH

04378

Reg. Dist. No.

737

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Malcolm</i>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Malcolm</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Home</i>				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>IRENE</i> Middle <i>ELIZABETH</i> Last <i>TURNER</i>				4. DATE OF DEATH Month <i>4</i> Day <i>18</i> Year <i>1956</i>							
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Col</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>MAY 30, 1900</i>		9. AGE (In years last birthday) <i>55</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Ben Wright</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Adams</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>BETHEL MOBLE</i> Address <i>Malcolm</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>442X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>Hypertensive cardiac disease</i> DUE TO (c) <i>yes</i>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>4-10</i> , 19 <i>56</i> , to <i>4-18</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>4-18</i> , 19 <i>56</i> , and that death occurred at <i>1:00 A.M.</i> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <i>Richard H. Dobson</i>				M.D. <i>Brunswick, Md.</i>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <i>Richard H. Dobson</i>				<i>Brunswick, Md.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <i>4/21/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Philip's</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home</i>				ADDRESS <i>2000</i>				24a. REC'D BY REGISTRAR <i>APR 24 1956</i>		24b. REGISTRAR'S SIGNATURE <i>John E. Danner</i>	

BUREAU V.

APR 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5 Film G196 5-7-56 et

4357

CERTIFICATE OF DEATH

Reg. Dist. No.

04379 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Prince Georges.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairmont Hts., Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's Gen. Hosp</u>		d. STREET ADDRESS <u>904-60th Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Vance</u>		4. DATE OF DEATH Month Day Year <u>April 18 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-5-1904</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trash Collector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trash Route</u>	
11. BIRTHPLACE (State or foreign country) <u>S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Vance</u>		14. MOTHER'S MAIDEN NAME <u>Lillie Ballinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-18-6781</u>	
17. INFORMANT Address <u>904 60th Ave Fairmount Hts.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>447X</u> DUE TO <u>uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Vascular Disease</u> DUE TO (c) <u>1 mo.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-12, 1956</u> to <u>4-18, 1956</u> , that I last saw the deceased alive on <u>4-18, 1956</u> , and that death occurred at <u>11:00</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel Sugar</u> M.D.		ADDRESS (Street, city or town, state) <u>Mr. Kanner, Md</u>	
PHYSICIAN'S NAME (Type) <u>SAMUEL SUGAR</u>		DATE SIGNED <u>4/18/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/21/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Washington & Sons</u>		ADDRESS <u>467 N. ST. N.W. Wash D.C.</u>	
24a. REC'D BY REGISTRAR <u>DATE 4/21/56</u>		24b. REGISTRAR'S SIGNATURE <u>Amanda Sawyer</u>	

BUREAU V. S.

APR 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4390 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>York County</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>		c. LENGTH OF STAY IN 1b <u>transit</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>York</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bowie Race Track</u>				d. STREET ADDRESS <u>738 West Princess</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Albert Martin Wagman</u>				4. DATE OF DEATH Month Day Year <u>April 9 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 June 1884</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meat cutter</u>		11. BIRTHPLACE (State or foreign country) <u>York County, Penn.</u>			
13. FATHER'S NAME <u>John H. Wagman</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Carr</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Edward Wagman, 945 Linden Ave., York, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) </div> <div style="width: 65%;"> <u>Acute congestive heart failure</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John J. Maloney</u>		EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>		DATE SIGNED <u>April 9, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Saviour Cemetery York Pa.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 11 1956</u>			
24b. REGISTRAR'S SIGNATURE <u>Mrs. Agnes Yingling</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, these exceptions apply: (1) If the word "pending" is penciled in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. (2) If the word "pending" is penciled in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. (3) If the word "pending" is penciled in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. (4) If the word "pending" is penciled in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. (5) If the word "pending" is penciled in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.

INVESTIGATIVE STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 11 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 1, 2, and 3 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4391 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04381

Reg. Dist. No.

242

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ritchie		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ritchie		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7180 Ritchie Road				d. STREET ADDRESS 7180 Ritchie Rd			
3. NAME OF DECEASED (Type or print) Emma Eator Walker				4. DATE OF DEATH April 6 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 11, 1879	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Clerk		11. BIRTH PLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles H. Walker				14. MOTHER'S MAIDEN NAME Mary A. Cresser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Patrick J. Murray, Bethesda, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Acute Congestive heart failure DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-9-56		22c. NAME OF CEMETERY OR CREMATORY Congressional		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Keelson				24a. REC'D BY REGISTRAR DATE Apr 9-56		24b. REGISTRAR'S SIGNATURE Edna F. Collins	

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. MANNER OF DEATH: [illegible]
9. SIGNATURE OF EXAMINER: [illegible]
10. DATE OF EXAMINATION: [illegible]

BUREAU V. S.

APR 16 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

4358 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

04382

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERKALE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
c. LENGTH OF STAY IN 1b 1 mo.		d. STREET ADDRESS 5112 Watson St. N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6204 60 Pl.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIND Middle EMILY Last WALKER		4. DATE OF DEATH Month 4 Day 1 Year 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-13-'73
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Wash DC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN R LUSKEY		14. MOTHER'S MAIDEN NAME MARY E STARLIGHT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Address EDGAR S WALKER 5112 WATSON ST. N.W.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X acute cardiac decompensation DUE TO (b) Hypertensive and arteriosclerotic cardiomegaly with lying cause last. (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —		INTERVAL BETWEEN ONSET AND DEATH 2 hr. 15 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-1, 1956, to 4-1, 1956, that I last saw the deceased alive on 4-1, 1956, and that death occurred at 3:50 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE R. D. Baker		ADDRESS (Street, city or town, state) 2513 Brookledge Rd. DATE SIGNED 4-1-56	
PHYSICIAN'S NAME (Type) R. D. BAKER M.D.		Nye & Hill M.D.	
22a. (BURIAL, CREMATION, REMOVAL (Specify))		22b. DATE THEREOF 4-3-56	
22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN		22d. LOCATION (City, town, or county) (State) BLADENSBURG MD	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 4812 GANUV		24a. REC'D BY REGISTRAR DATE April 3 1956	
DEAL FUNERAL HOME WASH DC		24b. REGISTRAR'S SIGNATURE Mrs. Jas. Severe	

PLACE OF DEATH A. HOME		MAYLAND	
DATE OF DEATH APR 5 1956		TIME OF DEATH 10:00 AM	
AGE 68		SEX M	
RACE W		EDUCATION H	
OCCUPATION RETIRED		MARRIAGE M	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
IMMEDIATE CAUSE OF DEATH CORONARY THROMBOSIS		MIDDLE CAUSE OF DEATH HYPERTENSION	
FUNDAMENTAL CAUSE OF DEATH ARTERIOSCLEROSIS		PRE-EXISTING DISEASES HYPERTENSION, CORONARY ARTERY DISEASE	
SIGNS AND SYMPTOMS PAIN IN CHEST, SHORTNESS OF BREATH, SWEATING		TREATMENT MEDICINE, SURGERY	
HISTORY ONset of symptoms on APR 4 1956		FAMILY HISTORY NONE	
SOCIAL HISTORY SMOKING, ALCOHOL		HABITS NONE	
MEDICAL HISTORY HYPERTENSION, CORONARY ARTERY DISEASE		SURGICAL HISTORY NONE	
PATHOLOGICAL FINDINGS CORONARY ARTERY DISEASE, HYPERTENSION		LABORATORY FINDINGS NONE	
POST-MORTEM FINDINGS NONE		OTHER FINDINGS NONE	
SIGNATURE OF PHYSICIAN J. H. SMITH		SIGNATURE OF REGISTRAR J. H. SMITH	
DATE APR 5 1956		TIME 10:00 AM	

RECEIVED
APR 5 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4359

CERTIFICATE OF DEATH

0438831

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seabrook, Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Whedbee</u> Last <u>Whedbee</u>				4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 8 1874</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James --</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Frank Whedbee Seabrook Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Pulmonary Infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombophlebitis</u> DUE TO <u>1 Hour</u> (c) <u>Generalized arteriosclerosis</u> DUE TO <u>1 mo</u> <u>1 year</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u> <u>1 mo</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>april 10, 1956</u> to <u>april 19, 1956</u> , that I last saw the deceased alive on <u>april 19, 1956</u> , and that death occurred at <u>3:47</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel J. Sugar</u>				ADDRESS (Street, city or town, state) <u>Mt Rainier Md</u>			
PHYSICIAN'S NAME (Type) <u> </u>				DATE SIGNED <u>april 19, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr 22, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Georges Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glendale Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>4/23/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Emmanuel Dourney</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED A. J. JONES		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 11/15/1910		5. PLACE OF BIRTH New York, N.Y.	
6. OCCUPATION Teacher		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 08/12/1935		9. PLACE OF MARRIAGE New York, N.Y.		10. NAME OF SPouse B. J. JONES	
11. CAUSE OF DEATH Heart Disease		12. PLACE OF DEATH Home		13. DATE OF DEATH 03/10/1956		14. TIME OF DEATH 10:30 AM		15. SIGNATURE OF PHYSICIAN J. H. Smith	
16. SIGNATURE OF DECEASED A. J. JONES		17. SIGNATURE OF NEXT OF KIN B. J. JONES		18. SIGNATURE OF WITNESS J. H. Smith		19. SIGNATURE OF DECEASED A. J. JONES		20. SIGNATURE OF NEXT OF KIN B. J. JONES	

BUREAU V. 2

APR 24 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
3
9, Film G195 4-12-56 et
CERTIFICATE OF DEATH

04384

Reg. Dist. No. 245

1. PLACE OF DEATH a. COUNTY <u>Pr. Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>13 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Keloland Memorial Hosp</u>		d. STREET ADDRESS <u>2754-73rd Pl.</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>White</u> Middle <u>White</u> Last		4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-16-79</u>
9. AGE (In years last birthday) <u>76 11/11</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Epis.</u>	
11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alfred E White</u>		14. MOTHER'S MAIDEN NAME <u>Emma Slater</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>hosp. records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>apoplexy</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertension C.V.D.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec</u> , 1953, to <u>April</u> , 1956, that I last saw the deceased alive on <u>April 4</u> , 1956, and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Thomas M. Hulet</u> M.D. <u>7315 Landover Rd. Hyattsville, D.C.</u> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>April 7, 56</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls</u>		22d. LOCATION (City, town, or county) (State) <u>Fairlee Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Clark</u> ADDRESS <u>Easton Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>James E. Lewis</u>			

RECEIVED

APR 9 1955

BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04385

4392

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Prince George's</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Pr. Goe's.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Clinton, Md.</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>Rt. # 2, Box. 560</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>NETTA</u>		(Middle) <u>V.</u>		(Last) <u>WHITE</u>		(Month) (Day) (Year) <u>April 14, 19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 2- 1880</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Camp Springs, Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Payne</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Day</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Lee White -Rt. #2, Box. 560 Clinton, MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
260x IMMEDIATE CAUSE (A) <u>Acute congestive cardiac failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiovascular heart disease</u>				<u>unknown</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes Mellitus</u>				<u>10 years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 14, 19 56</u> , to <u>April 14, 19 56</u> , that I last saw the deceased alive on <u>Apr 14, 19 56</u> , and that death occurred at <u>7:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James E. Smith</u>				ADDRESS (Street, city, town, state) <u>M.D. Washington 28 DC Apr 14 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 17-56</u>		NAME OF CEMETERY OR CREMATORY <u>Bell's M. E. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Camp Springs, Maryland.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Edna F. Collins</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros.</u>		ADDRESS <u>1661- Good Hope RD. SE Washington, D.C.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4361
CERTIFICATE OF DEATH

04386

Reg. Dist. No. 231

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley, Md.</u>		c. LENGTH OF STAY IN 1b <u>30 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges Gen. Hosp.</u>		d. STREET ADDRESS <u>11012 Montgomery</u>	
3. NAME OF DECEASED (Type or print) First <u>Ruby</u> Middle <u>M.</u> Last <u>White</u>		4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7/4/87</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired, Vet. Adm.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Wash, D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Abraham F. Springston</u>		14. MOTHER'S MAIDEN NAME <u>Emma I. Combs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>John P. Huebsch, 11012 Montgomery Rd.,</u>		Address <u>Beltsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pancreatic fibrosis</u> <u>587.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Biliary obstruction</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 y.s.</u> <u>5 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-10</u> , 19 <u>56</u> , to <u>4-30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-30</u> , 19 <u>56</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. D. Bauer</u>		DATE SIGNED <u>4/30/56</u>	
PHYSICIAN'S NAME (Type) <u>R. D. BAUER MD</u>		ADDRESS (Street, city or town, state) <u>2513 Buck Lodge Rd. Adelphi, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/3/56</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>5/2/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Theresa L. Bourne</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

04387

2411 N. Charles Street, Baltimore

4393

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE D. C. COUNTY -	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Glenn Dale (rural)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Dale Hospital		STREET ADDRESS Dumbar Hotel, 15th and U. Sts., NW	
3. NAME OF DECEASED (Type or Print) Chauncey Williams		4. DATE OF DEATH April 23 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Not legally separated.	8. DATE OF BIRTH 9/9/08
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Gun Factory	9. AGE last birthday 47 yrs.
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gordon Williams		14. MOTHER'S MAIDEN NAME Edith DeVaul	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. 578-42-1319	
17. INFORMANT AND ADDRESS Decedent			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Pulmonary Tuberculosis			4 yrs 2 mos.
Antecedent cause(s)			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan 1, 1955, to April 23, 1956, that I last saw the deceased

alive on April 23, 1956, and that death occurred at 1:35 A.M., from the causes and on the date stated above.

SIGNATURE Daniel P. Prucians M. D. ADDRESS Glenn Dale Hospital Glenn Dale, Md. DATE SIGNED 4/23/56

23. BURIAL, CREMATION, REMOVAL (Specify) Burial	DATE 4/23/56	NAME OF CEMETERY OR CREMATORY Washington D.C.	LOCATION (City, town, or county) (State) Washington D.C.
DATE REC'D BY LOCAL REG. 4/23/56	REGISTRAR'S SIGNATURE Not Warr	24. FUNERAL DIRECTOR Barnes Matthews	ADDRESS 614-4th St SW

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 27 1956

BUREAU V. S.

04388

MARYLAND

STATE DEPARTMENT OF HEALTH

4394

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Prince George's	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hillcrest Heights		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hillcrest Heights	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS 3319 Jamison St	
3. NAME OF DECEASED (Type or Print) John (First) 2 (Middle) Williams (Last)		4. DATE OF DEATH 4-9-1956 (Month) (Day) (Year)	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 4-28-1892 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machineist		10b. KIND OF BUSINESS OR INDUSTRY W & H Dry Goods	
11. BIRTHPLACE (State or foreign country) Wash DC		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W Williams		14. MOTHER'S MAIDEN NAME Margaret Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT AND ADDRESS Mildred Williams 3319 Jamison St	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 Immediate cause (a) Acute Myocardial Infarction			1 hour
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive heart disease (c) Congestive Failure			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY	
(CITY OR TOWN) (COUNTY) (STATE)		HOW DID INJURY OCCUR?	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from 4-16-1951, to 4-9-1956 that I last saw the deceased alive on 3-30-1956 and that death occurred at 2 P.m., from the causes and on the date stated above.			
SIGNATURE Lawrence D. Summerfield M.D.		ADDRESS 1400 Branch Ave. S.E. DATE SIGNED 4-9-56	
23. BURIAL, CREMATION REMOVAL (Specify) 4-11-1956		NAME OF CEMETERY OR CREMATORY Cedar Hill LOCATION (City, town, or county) Suitland Maryland (State)	
DATE REC'D BY LOCAL REG. apr. 9-1956		24. FUNERAL DIRECTOR John H. Mattingly ADDRESS 131-11 St NE Wash DC	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

APR 16 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4395

CERTIFICATE OF DEATH

04389

Reg. Dist. No. 732

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>PRINCE GEORGES</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Prince Georges</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Aguares</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Aguares</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>ROSSIE HERMAN WILLS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 4</u> 19 <u>56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>June 29, 1894</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lee Wills</u>				14. MOTHER'S MARDEN NAME <u>Alice Greenfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give year or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. —		17. INFORMANT & ADDRESS <u>Brother - Thomas H. Wills</u> <u>Brooklyn, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) <u>Cerebral Embolism</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension &</u>						at least	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Chronic Myocardial Disease</u>						6 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 1</u> , 19 <u>55</u> , to <u>Feb 25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/25</u> , 19 <u>56</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert M. Leon</u> M.D.				ADDRESS (Street, city, town, state) <u>Aguares Md.</u>		DATE SIGNED <u>4/4/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-7-56</u>		NAME OF CEMETERY OR CREMATORY <u>St Peter's Cem.</u>		LOCATION (City, town, or county) (State) <u>Waldorf, Maryland</u>	
24. REC'D BY REGISTRAR <u>APR 9 1956</u>		REGISTRAR'S SIGNATURE <u>John L. Danney</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home</u> ADDRESS <u>Waldorf, Md.</u>			

BUREAU V. S.

APR 9 1956

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4362

CERTIFICATE OF DEATH

Reg. Dist. No.

231

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>38 Cheverly</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pr. Geo's General Hospital</u>		d. STREET ADDRESS <u>-</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>H</u> Last <u>WILSON</u>		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 6, 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>75</u> Days <u>75</u> Hours <u>75</u> Min. <u>75</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Roads Comm.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. Eva Lusby</u>		Address <u>Mitchellville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO <u>910.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>gangrene, rt leg</u> DUE TO <u>910.0</u> (c) <u>-</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Window fallen leg</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>4-6-56</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. <u>4-6-56</u> p. m. <u>10:00</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>PG.</u> (County) <u>-</u> (State) <u>-</u>	
21. I certify that I attended the deceased from <u>4-13-56</u> to <u>4-16-56</u> , that I last saw the deceased alive on <u>4-16-56</u> , and that death occurred at <u>10:00 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald W. Mitchell</u>		M.D. <u>1746 R St NW, Wash DC</u>	
PHYSICIAN'S NAME (Type) <u>-</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/19/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Upper Marlboro Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros.</u>		ADDRESS <u>Upper Marlboro, Md.</u>	
24a. REC'D BY REGISTRAR <u>4/19/56</u>		24b. REGISTRAR'S SIGNATURE <u>Theresa L. Sunday</u>	

MEDICAL CERTIFICATION

16

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

PLACE OF DEATH HOME		PLACE OF BIRTH HOME	
SEX MALE		AGE 45	
RACE WHITE		OCCUPATION LABORER	
MARITAL STATUS SINGLE		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH APR 23 1956		TIME OF DEATH 10:00 AM	
NAME OF DECEASED CHARLES H. WILSON		NAME OF PHYSICIAN DR. J. H. SMITH	
NAME OF FUNERAL HOME J. H. SMITH		NAME OF BURIAL PLACE GREENWOOD CEMETERY	
NAME OF NEXT OF KIN MRS. J. H. SMITH		NAME OF WITNESS DR. J. H. SMITH	
SIGNATURE OF DECEASED (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF FUNERAL HOME (None)		SIGNATURE OF WITNESS (None)	

RECEIVED
 APR 23 1956
 BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
4396					MEDICAL EXAMINER'S CERTIFICATE OF DEATH				
Item 9, Film G197 5-14-56 et					Reg. Dist. No. 04391				
1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE <u>D.C.</u> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Luxedo</u>			c. LENGTH OF STAY IN 1b <u>3 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u> 478-3			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5708 Beecher Street</u>					d. STREET ADDRESS <u>657 Main Avenue</u>				
3. NAME OF DECEASED (Type or print) First <u>Elija</u> Middle <u>Wright</u> Last <u>Wright</u>					4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1956</u>				
5. SEX <u>Female</u>		6. COLOR OF RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1889</u>		9. AGE (In years last birthday) <u>65</u> yrs?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Tom Johnson</u>					14. MOTHER'S MARDEN NAME <u>Caroline Maiden</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>1429-58 in Ave</u>				
17. INFORMANT <u>Older Johnson</u>					Address <u>Chapel Bldg. Md</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular accident</u> DUE TO (c) <u>Essential hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiovascular renal disease</u>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
22a. BURIAL, CREMATION, REMOVAL (Specify) <input checked="" type="checkbox"/>					22b. DATE THEREOF <u>4/23/56</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>King George</u>					22d. LOCATION (City, town, or county) (State) <u>King George, Va.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas T. ...</u>					24a. REC'D BY REGISTRAR <u>4/23/56</u>				
24b. REGISTRAR'S SIGNATURE <u>Thomas T. ...</u>									

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint, illegible text]		SEX [Faint, illegible text]	
AGE [Faint, illegible text]		RACE [Faint, illegible text]	
DATE OF DEATH [Faint, illegible text]		TIME OF DEATH [Faint, illegible text]	
PLACE OF DEATH [Faint, illegible text]		CITY [Faint, illegible text]	
COUNTY [Faint, illegible text]		STATE [Faint, illegible text]	
OCCUPATION [Faint, illegible text]		CAUSE OF DEATH [Faint, illegible text]	
MANNER OF DEATH [Faint, illegible text]		SIGNATURE OF EXAMINER [Faint, illegible text]	
SIGNATURE OF WITNESS [Faint, illegible text]		SIGNATURE OF JURY [Faint, illegible text]	

BUREAU V. S.

APR 24 1956

RECEIVED